

It's Your Choice: 2013 Decision Guide

Group Health Insurance Plans



State of Wisconsin Employees
Retired State of Wisconsin Employees (Annuitants)
Members with Continuation Coverage (Continuants)
UW Graduate Assistants

Enrollment Period

October 8 to November 2, 2012

**Turn The Page
To Find The Information
Most Important To You**

The It's Your Choice: Decision Guide is filled with information to help eligible state employees and annuitants select one of the many health plans offered by the State of Wisconsin Group Health Insurance Program. Use the following to point you to essential information that is specifically relevant to you.

ANNUITANTS, be sure to read...

- Important Changes on Pages 2 through 6
- Medicare Eligibility in the It's Your Choice: Reference Guide
- Pharmacy Benefits on Pages 74 through 79
- Premium Rates on Pages 20 through 22
- Glossary beginning on Page 94

ACTIVE EMPLOYEES and GRADUATE ASSISTANTS, be sure to read...

- Important Changes on Pages 2 through 6
- Premium Rates on Pages 20 through 22
- Pharmacy Benefits on Pages 74 through 79
- Employee Reimbursement Accounts on Page 81



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*Photos courtesy of the Wisconsin Department of Tourism
and the Iron River Lions.*

Every effort has been made to ensure that the information in this booklet is accurate. In the event of conflicting information, state statute, state health contracts, and/or policies and provisions established by the State of Wisconsin Group Insurance Board shall be followed.



Oshkosh
Sawdust Days

Choose Wisely



Iron River
Blueberry Festival

IMPORTANT CHANGES — EFFECTIVE JANUARY 1, 2013

Generally, if you plan to stay with your current plan and you are not changing your coverage, you do not need to take any action during the It's Your Choice Open Enrollment period. However, you should review the following grid to understand how your coverage may change. If you have questions or concerns about any of these changes, contact your health plan using the information listed in the back of this Guide.

Coverage for Specialty Prescription Drugs

All plans

Specialty Drugs

- Specialty medications obtained from **Diplomat Specialty Pharmacy** are payable at:
 - \$15 for formulary drugs to a separate \$1,000 individual/\$2,000 family out-of-pocket limit.
 - \$50 for non-formulary specialty drugs with no out-of-pocket limit.
- Specialty medications obtained from another network pharmacy are payable at:
 - \$50 for formulary drugs to a separate \$1,000 individual/\$2,000 family out-of-pocket limit.
 - \$50 for non-formulary specialty drugs with no out-of-pocket limit.

See the *Uniform Benefits Schedule of Benefits* in the *It's Your Choice: Reference Guide* or contact Navitus Health Solutions for more information.

Health Risk Assessments (HRAs) and Biometric Screenings

All plans

HRAs are a great tool to help you understand and potentially improve your health. Every health plan will have one available, including biometric screenings. All plans offer incentives for completing them. Contact your plan for more information.



New Prior Authorization Requirements

All plans that offer Uniform Benefits (Insured HMOs, PPOs and SMP)

Prior authorization will be required for high-tech radiology (for example: MRI, PET and CT scans) and low back surgeries. Contact your health plan for more information. (Note: The Standard Plan also has some authorization requirements.)

Primary Care Physician (PCP) Selection

All plans

You are strongly recommended to select a primary care physician (PCP) or clinic for yourself and your covered dependents if you submit an application. This doctor would coordinate your care with specialists.

New Changes Resulting from Federal Law

All plans

- The federal list of preventive services that are allowed at 100% has been updated. See <http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html>.
- Federally required *Summaries of Benefits and Coverage* (SBCs) and the *Uniform Glossary* are available at: etf.wi.gov/members/health-plan-summaries.htm. If you need printed copies sent to you, please call the Department of Employee Trust Funds (ETF) at 1-877-533-5020 to let us know which plan's *Summary of Benefits and Coverage* you want.

Choose Wisely

New Health Plan

WPS Metro Choice Northwest	Offered in 11 counties in northwest Wisconsin including Barron, Burnett, Chippewa, Dunn, Eau Claire, Pierce, Polk, Rusk, Sawyer, St. Croix and Washburn.
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Health Plan Name and/or Provider Network Changes

Health plans listed below have made significant changes by adding or terminating contracts with provider groups in two or more counties. Other plans have also made changes. Refer to the map on Page 24 and call the health plan for more details.

Anthem Blue Northeast	Added providers in Door, Green Lake, Marinette, Oconto, Waupaca and Waushara counties
Anthem Blue Northwest	Added providers in Ashland, Douglas, Polk, St. Croix and Washburn counties
Humana Eastern	Added providers in Calumet, Door and Oconto counties
Physicians Plus	Primary care providers located at UW Health East, West, University Station and Oakwood clinics will no longer be available. Specialty providers at these locations will require approved prior-authorization. Providers at three new clinics, Meriter- Fitchburg, Stoughton and Dermatology, are now available. UW Hospital is no longer in-network, but out-of-network referrals may be available if prior approved by the health plan.
Security Health Plan	Will no longer offer providers in Green Lake and Vernon counties and is no longer qualified in Juneau county
WEA Trust PPO East (Formerly WEA Trust PPP East)	Expanding into Adams, Juneau, Langlade, Lincoln, Menominee and Taylor counties
WPS Metro Choice Southeast (Formerly WPS Metro Choice)	Expanding into Dodge and Jefferson counties

Health Plan Tier Changes

Anthem Blue - Northwest	Changing to Tier 3
WPS Metro Choice Southeast	Changing to Tier 3



Medicare Plus Coverage Changes

Medicare eligible participants who are enrolled in Medicare Plus	This plan is changed to fully supplement Medicare and allow for coverage during foreign travel. Some benefits, such as Medicare approved transplant coverage, will increase and others will decrease, such as skilled nursing care in a non-Medicare approved facility. However, the overall value of the program will not materially change.
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Changes to Dental Coverage

For more information, see the *Health Plan Description* pages in the *Choose Your Health Plan* section.

Anthem Blue	Adding: deductible of \$50 individual/\$150 family, 50% coverage after deductible for amalgam and composite fillings, \$500 individual annual maximum plan payment. For orthodontia, adding 50% coverage up to a \$500 lifetime maximum.
Network Health Plan	Increasing the age limit for sealants to 18. Decreasing the allowable frequency of X-rays to: bitewings once a year and full mouth once every five years.
Security Health Plan	Adding overall \$25 individual/\$50 family deductible and coverage for some basic services such as fillings at 50% up to an annual maximum of \$1,500. Orthodontia is covered at 50% up to a new lifetime maximum of \$1,500.

Choose Wisely

Other Information on ETF's Internet Site

All plans

The *It's Your Choice: Decision Guide* and *Reference Guide* are available at **etf.wi.gov**. Any known printing discrepancies will be clarified on this site. Other information is available about insurance programs, including the complete Report Card on health plans.

Sign up for ETF E-Mail Updates for the most current information at **etf.wi.gov**.

Online Help

All plans

Are you unsure where to start with the *It's Your Choice: Decision and Reference Guides*? ETF has an online tutorial to provide information on changes and services we offer. Find them on **etf.wi.gov** under the Group Health Insurance menu.

How can the Employee Reimbursement Account (ERA) program help to offset out-of-pocket medical costs?

Save money when you pay for out-of-pocket medical expenses through the ERA Program. A medical expense reimbursement account allows you to contribute tax-free money to pay for your family's health plan coinsurance, prescription drug copayments and other qualifying expenses that you pay out-of-pocket—such as dental, orthodontics and vision care. Federal law limits contributions to \$2,500 annually to a medical expense account. Review the 2013 ERA enrollment booklet at **etf.wi.gov** for information about how the ERA program can help you save money.

FREQUENTLY ASKED QUESTIONS

IT'S YOUR CHOICE OPEN ENROLLMENT PERIOD

The "It's Your Choice" Open Enrollment period is the annual opportunity for eligible employees and annuitants to select one of the many health plans offered by the State Group Health Insurance Program. Today, there are more than 18 different health plans to choose from.

The following list contains some of the most commonly asked questions about the enrollment period. You can also find information about key terms in the *Glossary* section at the back of this Guide.

NEW BENEFITS AND ELIGIBILITY CHANGES

1. What is the It's Your Choice Open Enrollment period?

The It's Your Choice Open Enrollment period is an opportunity to change plans, change from family to single coverage, enroll if you had previously deferred coverage, cancel your coverage, or cancel the coverage for your adult dependent child. It is offered only to employees, annuitants and surviving spouses and

dependents who are eligible under the State of Wisconsin Group Health Insurance Program. Changes made become effective January first of the following year.

2. What are routine or preventive services, and why are they treated differently than treatment of an illness or injury?

Routine, preventive care is care that is designed to help prevent disease, or to diagnose it in the early stages. Federal health care reform requires first dollar coverage of preventive care services when grandfathering is lost as a result of significant benefit and/or premium changes. The list of federally required preventive services is available at: <http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html>. Your provider uses standardized codes to bill your insurer for services. These codes require providers, when performing a non-trivial treatment of an illness or injury, to separate the claim from the preventive service. In general, don't expect to have the evaluation or treatment of an illness or injury paid as preventive when it occurs during a preventive exam.

SEE THE **IT'S YOUR CHOICE: REFERENCE GUIDE FREQUENTLY ASKED QUESTIONS** SECTION FOR INFORMATION REGARDING DEPENDENT ELIGIBILITY, FAMILY STATUS CHANGES AND HOW TO USE YOUR BENEFITS.

Choose Wisely

3. How does the prescription drug benefit work for the Level 4 copay for specialty and certain other medications?

Formulary and non-formulary prescription drugs that are classified by Navitus as specialty medications have a Level 4 copayment of \$50 when they are filled at a participating network pharmacy. The \$50 copayment for formulary specialty drugs counts toward your \$1,000/\$2,000 Level 4 out-of-pocket limit (OOPL). Copayments for non-formulary specialty drugs do not count toward the Level 4 OOPL.

We strongly encourage you to participate in the Navitus SpecialtyRx, specialty pharmacy program. If you have your prescriptions for specialty drugs filled at the preferred participating pharmacy for specialty medications, which is currently Diplomat Specialty Pharmacy, you will have a reduced copayment of \$15 for formulary specialty drugs (which also counts toward the Level 4 OOPL). These drugs will be marked with “ESP” on the formulary. This also allows you to take advantage of the additional, personalized services available with the Navitus SpecialtyRx, specialty pharmacy program. Non-formulary specialty and certain other drugs are not eligible for the reduced copayment, and the copayments do not count toward the Level 4 OOPL.

To enroll in the Navitus SpecialtyRx specialty pharmacy program or to obtain additional information,

call 1-877-651-4943 or visit diplomatpharmacy.com.

THINGS TO CONSIDER DURING IT'S YOUR CHOICE OPEN ENROLLMENT

4. May I change from single to family coverage during the It's Your Choice Open Enrollment period?

Yes, you have the opportunity to change from single to family coverage without a waiting period or exclusions for preexisting medical conditions. Coverage will be effective January 1 of the following year for all eligible dependents. Note that if you are subject to tax liability for dependents such as adult children, and/or a domestic partner and his or her child(ren), you can elect not to cover such individuals. For information about the tax impact of covering non-tax dependents, see *Frequently Asked Question 5*.

For information on changing from family to single coverage, see the *Frequently Asked Question* section of the *It's Your Choice: Reference Guide*.

5. What are the tax implications for covering non-tax dependents?

Domestic Partners: The fair market value for insurance coverage provided for a domestic partner and his or her children must be calculated and added to your income, unless the domestic partner and his or her children qualify as your tax dependents.

The fair market value of the health insurance benefits will be calculated and added to your earnings as *imputed income* (see *Frequently Asked Question 6* for definition). The monthly imputed income amounts vary by health plan and are provided for either one non-tax dependent, or two or more non-tax dependents. These dollar amounts will be adjusted annually and are available from your employer. Annuitants who have family coverage may cover non-tax dependents. If the premium is paid directly by the annuitant or through annuity deduction, there will be no imputed income on the value of the non-tax dependent's coverage. However, if the premium is being paid using accumulated sick leave conversion credits, the value of the non-tax dependent's coverage will be added to the annuitant's earnings as imputed income on a W-2 from ETF in January.

Employees who are unsure if a person can be claimed as a dependent should consult IRS Publication 501 or a tax advisor.

Employees may change from single to family coverage to add a newly eligible domestic partner or other dependent who does not qualify as a tax dependent under Internal Revenue Code Section 152 during the plan year. The additional premium attributable to the non-qualified dependent will be taxable.

Adult Children: The Patient Protection and Affordable Care Act (PPACA) and 2011 Wisconsin Act 49 eliminated

tax liability for the fair market value of health coverage for these dependents through the month in which they turn 26 if eligible.

If the tax dependent status of your dependent over age 26 changes, please notify your employer or for annuitants and continuants, ETF.

6. What is imputed income?

Imputed income is the non-cash benefit earned for items (e.g., health insurance for certain dependents) that is reported as income to the government on the W-2 and other forms. Employees and annuitants may be taxed on the fair market value of the health care coverage extended to their dependents who do not qualify as dependents for tax purposes.

See Question 5 to learn when imputed income applies. For more information, employees should contact their employer and annuitants should contact ETF.

7. If I do not change from single to family coverage during the It's Your Choice Open Enrollment period, will I have other opportunities to do so?

There are other opportunities for coverage to be changed from single to family coverage without restrictions as described below:

1. If an electronic or paper application is received by your benefits/payroll/personnel office for active employees or ETF for annuitants/continuant within 30 days of the following events,

Choose Wisely

coverage becomes effective on the date of the following event:

- Marriage.
 - The date ETF receives the completed *Affidavit of Domestic Partnership* form (ET-2371).
 - You or any of your eligible dependents involuntarily lose eligibility for other medical coverage or lose the employer contribution for the other coverage.
 - Legal guardianship is granted.
 - An unmarried parent whose only eligible child becomes disabled and thus is again an eligible dependent. Coverage will be effective the date eligibility was regained.
2. If an application is received by your benefits/payroll/personnel office for active employees or ETF for annuitants/continuant, within 60 days of the following events, coverage becomes effective on the date of the following event:
- Birth or adoption of a child or placement for adoption (timely application prevents claim payment delays).
 - A single father declaring paternity. Children born outside of marriage become dependents of the father on the date of the court order declaring paternity, on the date the acknowledgement of paternity is filed with the

Department of Health Services (or equivalent if the birth was outside of the state of Wisconsin), or on the date of birth with a birth certificate listing the father's name. The effective date of coverage will be the birth date, if a statement of paternity is filed within 60 days of the birth. If filed more than 60 days after the birth, coverage will be effective on the first of the month following receipt of application.

3. If an application is received by your benefits/payroll/personnel office for active employees or ETF for annuitants/continuant, upon order of a federal court under a National Medical Support Notice, coverage will be effective on either:
- The first of the month following receipt of application by the employer; or
 - The date specified on the Medical Support Notice.

Note: This can occur when a parent has been ordered to insure one or more children who are not currently covered.

8. Which other changes can only be made during the It's Your Choice Open Enrollment period if my health insurance premiums are taken pre-tax?

During the annual enrollment period, you can add or drop coverage for yourself and/or your adult dependent

children or do a spouse/domestic partner to spouse/domestic partner transfer of your health insurance coverage.

9. Are my health insurance premiums deducted from my paycheck on a pre-tax or post-tax basis?

The health insurance premiums for employees are automatically deducted from your paycheck on a pre-tax basis. This is often referred to as Automatic Premium Conversion. This means that you save on federal and state income tax, and FICA taxes (Social Security and Medicare taxes). This is a permanent tax exclusion, no taxes will be owed at a later date.

IMPORTANT NOTE: When premiums are deducted on a pre-tax basis, Internal Revenue Code regulations governing premium conversion restrict changes that can be made to your health insurance benefits during the plan year. You may not make changes or cancel your participation in the health plan during the plan year unless your decision to do so is a result of a qualifying change in status event and is allowed by the health plan rules. For more information, see the *It's Your Choice: Reference Guide Frequently Asked Question 22, When can I change from family to single coverage?* and *15, What are my coverage options if my spouse/domestic partner is also a State of Wisconsin or participating Wisconsin Public Employer (WPE) employee or state annuitant?*

If you wish to pay your premiums on a post-tax basis, you may fill out

an *Automatic Premium Conversion Waiver/Revocation of Waiver* form (ET-2340) and return it to your payroll/benefits office before the end of the year. Post-tax premium deductions will begin with the January deduction. Once you have filed a waiver, it will remain in effect for future plan years unless you file another *Automatic Premium Conversion Waiver/Revocation of Waiver* form (ET-2340) to revoke the waiver.

Annuitants: Since your premiums are not taken from a paycheck, they are considered post-tax.

10. What if my spouse is also a state of Wisconsin employee, annuitant or the eligible employee or insured annuitant of a Wisconsin Public Employer who participates in the State of Wisconsin Group Health Insurance Program?

If your spouse is also an eligible state employee or annuitant:

- you may each retain or select single coverage with your current plan(s); or
- one of you may retain or select family coverage under one of your current plans, which will cover your spouse and any eligible dependents.

See *Frequently Asked Question 15* in the *It's Your Choice: Reference Guide* for details. It's available electronically on ETF's Internet site at **etf.wi.gov**.

Note: For domestic partners, further information is available on the Internet site at **etf.wi.gov**.

HOW DO I MAKE CHANGES DURING IT'S YOUR CHOICE OPEN ENROLLMENT?

11. How do I change health plans during It's Your Choice Open Enrollment?

If you decide to change to a different plan, you* are encouraged to make changes online using the myETF Benefits website (see Pages 82 and 83 of this Guide), or you may submit a paper application using the following instructions:

- *Active employees may use the application in the back of this Guide, get one from ETF's Internet site at etf.wi.gov/publications/et2301.pdf or receive paper applications from your benefits/payroll/personnel office to complete and return to that office.
- Annuitants and continuants should complete the application found in the back of this Guide or get one from ETF's Internet site at etf.wi.gov/publications/et2301.pdf and submit it to ETF.

Applications received after the deadline will not be accepted.

Note: If you plan to stay with your current plan for next year and you are not changing your coverage, you do not need to take any action.

12. How do I use the myETF Benefits website?

Refer to Pages 82 and 83 in this Guide.

13. What happens if I enter my changes online, but did not submit them?

Your changes will not be stored unless you click on the **Submit** button. You will need to log back in and make the changes again. To view what you submitted, click the **myRequests** button on the bottom of the **myInfo** page.

14. What is the effective date of changes made during the It's Your Choice Open Enrollment period?

It's Your Choice coverage changes are effective January 1 of the following year.

15. What if I change my mind about the health plan I selected during the It's Your Choice Open Enrollment period?

You may submit or make changes anytime during the It's Your Choice Open Enrollment period, either online using the myETF Benefits website or by filling out a paper application. After that time, you may rescind, that is, withdraw your application (and keep your current coverage) by following these instructions before December 31:

- active employees should inform their benefits/payroll/personnel office; or
- annuitants and continuants should notify ETF.

Other rules apply when cancelling coverage. For more information, see the Cancellation/Termination of Coverage section of the *Frequently*

*Employees of the University of Wisconsin must visit the UW System fall enrollment website at <http://uwservice.wisc.edu/2013> for enrollment instructions.

Asked Questions in the It's Your Choice: Reference Guide.

SELECTING A HEALTH PLAN

16. How do I select a health plan?

You will want to:

- Determine which plans have providers in your area by reviewing the Health Plan map on Page 25.
- Contact the health plans directly for information regarding available physicians, medical facilities and services.
- Review the Health Plan Report Card in the *Choose Quality* section in this Guide and at **etf.wi.gov**.
- Review the plan descriptions in the *Choose Your Health Plan* section.
- Compare the premium rates and contributions beginning on Page 20.
- Compare the health plan features grid.

17. Can family members covered under one policy choose different health plans?

No, family members are limited to the plan selected by the subscriber.

18. Can I receive medical care outside of my health plan network?

This can be a concern for members who travel and those with covered dependents living elsewhere, such as a college student living away from home. Consider the following when selecting a health plan:

- If you are covered through an HMO, you are required to obtain allowable care only from providers in the HMO's network. HMOs will cover emergency care outside of their service areas, but you must get any follow-up care to the emergency from providers in the HMO's network. Do not expect to join an HMO and get a referral to a non-HMO physician. An HMO generally refers outside its network only if it is unable to provide needed care within the HMO.
- If you are covered through a Preferred Provider Organization (PPO) such as WPS Metro Choice, WEA Trust PPO or the Standard Plan, you have the flexibility to seek care outside a particular service area. However, out-of-network care is subject to higher deductible and coinsurance amounts.
- **Annuitants only:** If you or your dependents are covered through the Medicare Plus plan, you have the freedom of choice to see any available provider for covered services.

In addition, Humana's Medicare Advantage-Preferred Provider Organization offers coverage for participants with Medicare Parts A and B, with both in- and out-of-network benefits. **Note:** Non-Medicare members are limited to Humana's HMO network.

Choose Wisely

19. How can I get a listing of the physicians participating in each plan?

Contact the plan directly or follow the instructions provided in the *Health Plan Descriptions* section. ETF and your benefits/payroll/personnel office do not have this information.

OTHER ITEMS OF NOTE

20. What do I need to do when my spouse/domestic partner or I become eligible for Medicare?

Most people become eligible for Medicare at age 65, but you may or may not need to sign up. For some people, Medicare eligibility occurs earlier due to disability or End Stage Renal Disease. See the Medicare Information in the *Benefit and Services* section of the *It's Your Choice: Reference Guide* for full details.

21. What is Humana's Medicare Advantage Plan?

Humana offers a Medicare Advantage Preferred Provider Organization (MA-PPO) for members who have Medicare Parts A and B as their primary coverage.

When you use in-network providers, your benefits will be modeled on Uniform Benefits. When you use out-of-network providers, however, you will have greater out-of-pocket expenses for most services, for example, a 10% coinsurance up to a maximum of \$500 per individual.

You must be enrolled in Medicare Parts A and B to be eligible for a health plan's MA-PPO. You should

keep your Medicare card in a safe place, but you should not show it when you receive health care services, as the MA-PPO plan will be primary for your service. Contact Humana for further information including a list of in-network providers.

22. What is the Social Security Income Related Monthly Adjusted Amount (IRMAA) and does it affect me?

If your modified adjusted gross income exceeds certain limits established by federal law, you may be required to pay an adjustment to your monthly Medicare Part B (medical) and Medicare Part D (prescription drug) coverage premiums. The additional premium amount you will pay for Medicare Part B and Medicare prescription drug coverage is called the income-related monthly adjustment amount or IRMAA. Since Medicare beneficiaries enrolled in the State of Wisconsin Group Health Insurance Program are required to have Medicare Parts A, B and D, the IRMAA may impact you if you have higher income.

To determine if you will pay the additional premiums, Social Security uses the most recent federal tax return that the IRS provides them and reviews your modified adjusted gross income. Your modified adjusted gross income is the total of your adjusted gross income and tax-exempt interest income.

Social Security notifies you in November about any additional premium amounts that will be due for coverage in the next year because

of the IRMAA. You must pay the additional premium amount, which will be deducted from your Social Security check if it's large enough. Failure to pay may result in Medicare terminating your coverage. The IRMAA is paid to Social Security — not the State of Wisconsin Group Health Insurance Program. It is not included in your State of Wisconsin Group Health Insurance Program premium.

Additional information can be found in SSA Publication No. 05-10536 (<http://www.socialsecurity.gov/pubs/10536.html>) or by calling the SSA toll-free at 1-800-772-1213.

23. What if I have a child who is disabled and I am changing health plans during It's Your Choice?

Each health plan has the responsibility to determine whether or not a newly enrolled disabled dependent continues to meet the contractual definition of disabled dependent. (See the *Dependent Information* contained in the *It's Your Choice: Reference Guide* for full details.)

Fall of 2012 Health/Benefit Fair Dates and Locations

October 2012

City	Date	Time
Boscobel	Oct. 11	8:30 a.m. - 3:30 p.m.
Department of Corrections Wisconsin Secure Program Facility 1101 Morrison Drive		
Eau Claire	Oct. 9	8:00 a.m. - 11:30 a.m.
Department of Transportation 718 West Clairemont Avenue Chippewa Valley Conference Room		
Eau Claire	Oct. 9	10:00 a.m. - 1:00 p.m.
UW Eau Claire - Davies Center 105 Garfield Potawatomi and Arrowhead Rooms		
Green Bay	Oct. 8	Noon - 3:00 p.m.
UW Green Bay - University Union 2420 Nicolet Drive Phoenix Rooms A and B		
Green Bay	Oct. 25	8:00 a.m. - Noon
Department of Transportation DTSD 944 Vanderperren Way Green Bay and Lake Michigan Rooms		
Kenosha	Oct. 17	11:00 a.m. - 2:00 p.m.
UW Parkside - Student Center 900 Wood Road, University Ballroom		
King	Oct. 4	10:00 a.m. - 2:00 p.m.
Wisconsin Veterans Home N2665 County QQ Marden Memorial Center, Multipurpose Room		
La Crosse	Oct. 18	10:00 a.m. - 2:00 p.m.
UW La Crosse - Cartwright Center 1725 State Street Valhalla Conference Room		

October 2012

City	Date	Time
Madison	Oct. 4	10:00 a.m. - 2:00 p.m.
Department of Natural Resources (GEF 2) 101 South Webster, Conference Room G09, Ground Floor (Enter plaza door between GEF 2 and GEF 3 Buildings)		
Madison	Oct. 9	9:00 a.m. - 3:00 p.m.
UW Madison - Union South 1803 West Dayton Street		
Madison	Oct. 10	9:00 a.m. - 1:00 p.m.
Department of Transportation Hill Farms State Office Building 4802 Sheboygan Avenue, Room 364		
Madison	Oct. 11	9:00 a.m. - 1:00 p.m.
Department of Revenue 2135 Rimrock Road Events Room, First Floor		
Madison	Oct. 11	10:00 a.m. - 2:00 p.m.
Department of Health Services 1 West Wilson Street Conference Room 751, Seventh Floor (Enter center door; take elevator)		
Madison	Oct. 16	8:00 a.m. - Noon
Department of Transportation 2101 Wright Street Rock, Dane and Columbia Rooms		
Madison	Oct. 17	11:00 a.m. - 1:00 p.m.
DATCP Lobby of Prairie Oaks Building 2811 Agriculture Drive		
Mauston	Oct. 10	9:00 a.m. - 4:00 p.m.
Department of Health Services - Sand Ridge Secure Treatment Center 1111 North Road, H Training Center		

Fall of 2012 Health/Benefit Fair Dates and Locations

October 2012

City	Date	Time
Menomonie	Oct. 10	10:00 a.m. - 2:00 p.m.
UW Stout Price Commons Glass Lounge 1110 South Broadway		
Milwaukee	Oct. 3	10:00 a.m. - 3:30 p.m.
UW Milwaukee, Student Union 2200 East Kenwood Boulevard Wisconsin Room (Third Floor)		
Milwaukee	Oct. 9	10:00 a.m. - 1:00 p.m.
Milwaukee State Office Building (DOA) 819 North Sixth Street, Room 40		
Milwaukee	Oct. 11	10:00 a.m. - 1:00 p.m.
Department of Natural Resources 2300 North Martin Luther King Jr. Drive Rooms 140 and 141		
Oshkosh	Oct. 11	1:00 p.m. - 3:00 p.m.
UW Oshkosh, Reeve Memorial Union 748 Algoma Boulevard Ballroom 227 A and B		
Platteville	Oct. 3	Noon - 4:00 p.m.
UW Platteville, Ullsvik Hall 1 University Plaza, Velzy Commons (Located at West Main and South Hickory Streets)		
Plymouth	Oct. 9	5:30 a.m. - 3:30 p.m.
Kettle Moraine Correctional Institution W9071 Forest Drive Training Center		
Portage	Oct. 9	8:00 a.m. - 4:30 p.m.
Wisconsin DOC DAI, Columbia Correctional Institution, 2925 Columbia Drive Visiting Room		

October 2012

City	Date	Time
Rhineland	Oct. 17	9:00 a.m. - Noon
Department of Transportation 510 North Hanson Lake Road Oneida Conference Room		
River Falls	Oct. 3	10:00 a.m. - 1:30 p.m.
UW River Falls University Center 500 East Wild Rose Avenue Riverview Ballroom		
Stevens Point	Oct. 16	10:00 a.m. - 2:30 p.m.
UW Stevens Point, Dreyfus University Center 1015 Reserve Street, Alumni Room		
Superior	Oct. 10	8:00 a.m. - 11:30 a.m.
Department of Transportation 1701 North Fourth Street Lake Superior Conference Room		
Superior	Oct. 10	1:00 p.m. - 3:00 p.m.
UW Superior Yellowjacket Union 1605 Catlin Avenue, Room 203		
Waukesha	Oct. 18	8:00 a.m. - Noon
WisDOT Southeast Region 141 NW Barstow Street, Room 151		
Wausau	Oct. 15	10:00 a.m. - 4:00 p.m.
Wisconsin State Patrol 2805 Martin Avenue Downstairs conference room		
Wisconsin Rapids	Oct. 10	9:00 a.m. - Noon
Department of Transportation 1681 Second Avenue South Rooms 120 and 124		

Choose Your Health Plan

INTRODUCTION TO HEALTH PLAN OPTIONS

Green Bay
Bayfest



As a participant in the State of Wisconsin Group Health Insurance Program, all of the health plans listed in this booklet are available to you. This includes 18 private insurers (also called the “Alternate Plans”), the “Standard Plan,” and “State Maintenance Plan” (SMP). All of these options are described in more detail below. Definitions of terms also appear in the *Glossary* at the back of this Guide. You will want to choose the plan that works best for you, based on the location of providers, the premium costs and the quality of the care they deliver.

ALTERNATE HEALTH PLANS

Nearly 98% of current state employees choose coverage through the Alternate Plans. These include 16 health maintenance organizations (HMOs) and two preferred provider organizations (PPOs). These health plans all administer a “Uniform Benefits” package, meaning you will receive the same package of covered benefits and services, regardless

of your health plan selection. Note, benefits differ for those annuitants and their dependents who are enrolled in Medicare, versus all other members. Uniform Benefits is described in detail in the *It’s Your Choice: Reference Guide*.

You should be aware that there are differences among the Alternate Health Plans, and these can change annually. When choosing a health plan, you should consider the following:

- **Premium:** As an employee, your total monthly premium contribution amount can vary, depending on the health plan’s Tier ranking. A description of the tiering system appears on Page 20.
- **Provider Network:** The location, quantity, quality and availability of the doctors, clinics, hospitals and emergency/urgent care centers differ for each health plan.
- **Dental Benefits (if offered):** The location and availability of dental benefits and providers differ for each plan.
- **Benefit Determinations:** While all Alternate Plans offer the Uniform Benefits package, this does not mean that all will treat all illnesses or injuries in an identical manner. Treatment will vary depending on patient needs, the physicians’ preferred practices, and the health plan’s managed care policies and procedures.
- **Administrative Requirements:** Health plans may require you to select a primary care provider (PCP), get a

referral from your PCP before seeing a specialist or get a prior authorization before obtaining certain services such as for high-tech radiology (for example: MRI, PET and CT scans) and low back surgeries.

STATE MAINTENANCE PLAN (SMP)

The SMP is available only in counties that lack a qualified Tier 1 Alternate Plan HMO or PPO. It offers the same Uniform Benefits package as the Alternate Plans.

STANDARD PLAN

The Standard Plan is a PPO administered by WPS. The Standard Plan provides you with comprehensive freedom of choice among hospitals and physicians across Wisconsin and nationwide. You can compare the Standard Plan to the Uniform Benefits package using the Comparison of Benefits Options chart starting on Page 27. Please note that the Standard Plan is a Tier 3 health plan for employees, meaning that your premium contribution will be higher if you select this option.

HEALTH PLANS AVAILABLE TO ANNUITANTS

Medicare Coordinated Plans

All state health plans have coverage options which are coordinated with Medicare. You will remain covered by the health plan you select after you are enrolled in Medicare Parts A and B. The following exceptions apply:

1. Annuitants and their dependents who become Medicare eligible will be moved into the Medicare Uniform Benefits plan. See the *Comparison of Benefit Options* starting on Page 27 for more information.
2. Members enrolled in the Standard Plan or the SMP will be moved to the Medicare Plus plan on the member's Medicare effective date. See the *Comparison of Benefit Options* starting on Page 27 for more information.
3. Members enrolled in Humana will be enrolled in Humana's Medicare Advantage Preferred Provider Organization (MA-PPO) after you enroll in Medicare Parts A and B. See the *Plan Description Pages* for more information.

Medicare Plus is a fee-for-service Medicare supplement plan administered by WPS. This plan is available to eligible annuitants enrolled in Medicare Parts A and B. Medicare Plus permits you and your eligible dependents to receive care from any qualified health care provider anywhere in the world for treatment covered by the plan. You may be responsible for filing claims and for finding the providers who can best meet your needs.

Medicare Advantage Preferred Provider Organization (MA-PPO) allows members to use any health care provider; however, you will have greater out-of-pocket expenses when you use out-of-network providers. The in-network MA-PPO benefit is modeled to replicate the Uniform Benefits package.

Choose Your Health Plan

HEALTH PLAN 2013 PREMIUM RATES



ACTIVE EMPLOYEES

The Group Insurance Board and its consulting actuaries rank and assign each of the available health plans to one of three “**Tier**” categories, based on its efficiency and quality of care. Your premium contribution is determined by the Tier ranking of your health plan.

This approach encourages our members to choose the plans that are most efficient in providing quality health care. Likewise, this provides a strong incentive for our plans to hold down costs and deliver quality services.

Employee contribution rates and premium amounts for calendar year 2013 are provided to the right and on the following page.

ANNUITANTS AND CONTINUANTS

Premium amounts for calendar year 2013 appear on Page 22. These premium amounts may be withdrawn from your

accumulated sick leave conversion credits, WRS annuity payment, or you may be directly billed by your health plan.

You and your dependents who are eligible for Medicare must be enrolled in Parts A and B upon retirement or when initially eligible. When you and/or your dependents are enrolled, your group health insurance coverage will be coordinated with Medicare and your monthly premium will be reduced.

2013 Employee Contribution Rates

State of Wisconsin Employees (Except as stated below*)		
Tier	Single Rate	Family Rate
Tier – 1	\$85.00	\$211.00
Tier – 2	\$124.00	\$312.00
Tier – 3	\$230.00	\$575.00

State Patrol Titled Classifications		
Tier	Single Rate	Family Rate
Tier – 1	\$31.00	\$78.00
Tier – 2	\$69.00	\$173.00
Tier – 3	\$164.00	\$412.00

UW Graduate Assistants		
Tier	Single Rate	Family Rate
Tier – 1	\$42.50	\$105.50
Tier – 2	\$62.00	\$156.00
Tier – 3	\$115.00	\$287.50

Note: Employees scheduled to work less than 1,044 hours (50% of full time) pay 50% of the total monthly premium.

**For employees of the University of Wisconsin Hospital or other quasi-governmental authorities, questions about your premium contribution amounts should be directed to your benefits/payroll/personnel office.*

State of Wisconsin Employees, UW Graduate Assistants

2013 Total Monthly Premium Rates

Plan Name	Plan Tier	State of Wisconsin Employees		UW Graduate Assistants	
		Single	Family	Single	Family
Anthem Blue - Northeast	1	668.20	1,665.80	444.10	1,105.50
Anthem Blue - Northwest	3	770.40	1,921.30	515.60	1,284.20
Anthem Blue - Southeast	1	736.40	1,836.30	488.10	1,215.50
Arise Health Plan	1	722.30	1,801.00	514.20	1,280.70
Dean Health Plan	1	618.30	1,541.00	409.20	1,018.20
Group Health Cooperative of Eau Claire	1	721.30	1,798.50	513.30	1,278.50
GHC of South Central Wisconsin	1	596.70	1,487.00	412.70	1,027.00
Gundersen Lutheran Health Plan	1	760.30	1,896.00	488.20	1,215.70
Health Tradition Health Plan	1	748.70	1,867.00	501.20	1,248.20
HealthPartners	1	668.80	1,667.30	474.10	1,180.50
Humana - Eastern	1	752.10	1,875.50	510.90	1,272.50
Humana - Western	1	752.10	1,875.50	510.90	1,272.50
Medical Associates Health Plan	1	682.80	1,702.30	454.40	1,131.20
MercyCare Health Plans	1	605.70	1,509.50	374.00	930.20
Network Health Plan	1	713.80	1,779.80	466.20	1,160.70
Physicians Plus	1	620.70	1,547.00	383.70	954.50
Security Health Plan	1	764.40	1,906.30	545.80	1,359.70
Standard Plan	3	1,204.30	3,007.10	906.70	2,263.00
State Maintenance Plan	1	745.30	1,859.10	563.40	1,404.50
UnitedHealthcare of Wisconsin NE	1	708.70	1,767.00	502.80	1,252.20
UnitedHealthcare of Wisconsin SE	1	724.30	1,806.00	506.60	1,261.70
Unity - Community	1	716.80	1,787.30	510.10	1,270.50
Unity - UW Health	1	629.80	1,569.80	444.90	1,107.50
WEA Trust PPO - East	1	756.50	1,886.50	539.90	1,345.00
WEA Trust PPO - Northwest	1	777.80	1,939.80	555.80	1,384.70
WPS Metro Choice Northwest	1	745.70	1,859.50	511.70	1,274.50
WPS Metro Choice Southeast	3	866.30	2,161.00	598.50	1,491.50

Out-of-state residents assigned to work out of state receive the Standard Plan at a Tier 2 level.
The graduate assistant program does not offer Medicare reduced rates.

Retired State of Wisconsin Employees & Continuant

2013 Total Monthly Premium Rates

Plan Name	Annuitants and Continuant				
	Non-Medicare		Medicare Rates*		
	Single	Family	Medicare Single	Medicare 1	Medicare 2
Anthem Blue - Northeast	668.20	1,665.80	399.10	1,064.10	795.00
Anthem Blue - Northwest	770.40	1,921.30	450.20	1,217.40	897.20
Anthem Blue - Southeast	736.40	1,836.30	432.90	1,166.10	862.60
Arise Health Plan	722.30	1,801.00	426.10	1,145.20	849.00
Dean Health Plan	618.30	1,541.00	344.60	959.07	686.00
Group Health Cooperative of Eau Claire	721.30	1,798.50	382.30	1,100.40	761.40
GHC of South Central Wisconsin	596.70	1,487.00	363.30	956.80	723.40
Gundersen Lutheran Health Plan	760.30	1,896.00	286.70	1,043.80	570.20
Health Tradition Health Plan	748.70	1,867.00	438.50	1,184.00	873.80
HealthPartners	668.80	1,667.30	399.40	1,065.00	795.60
Humana - Eastern	752.10	1,875.50	316.60	1,065.50	630.00
Humana - Western	752.10	1,875.50	316.60	1,065.50	630.00
Medical Associates Health Plan	682.80	1,702.30	344.20	1,023.80	685.20
Medicare Plus**	NA**	NA**	288.60	NA**	573.90
MercyCare Health Plans	605.70	1,509.50	317.60	920.10	632.00
Network Health Plan	713.80	1,779.80	375.00	1,085.60	746.80
Physicians Plus	620.70	1,547.00	331.10	948.60	659.00
Security Health Plan	764.40	1,906.30	447.10	1,208.30	891.00
Standard Plan**	1,204.30	3,007.10	NA**	1,500.60	NA**
State Maintenance Plan**	745.30	1,859.10	NA**	1,039.00	NA**
UnitedHealthcare Northeast	708.70	1,767.00	419.30	1,124.80	835.40
UnitedHealthcare Southeast	724.30	1,806.00	427.10	1,148.20	851.00
Unity - Community	716.80	1,787.30	391.40	1,105.00	779.60
Unity - UW Health	629.80	1,569.80	352.30	978.90	701.40
WEA Trust PPO - East	756.50	1,886.50	443.20	1,194.50	883.20
WEA Trust PPO - Northwest	777.80	1,939.80	453.90	1,228.50	904.60
WPS Metro Choice Northwest	745.70	1,859.50	437.80	1,180.30	872.40
WPS Metro Choice Southeast	866.30	2,161.00	498.10	1,361.20	993.00

***Members on Medicare:** Definitions of Medicare 1 and Medicare 2 appear in the Glossary of this Guide.

**Members with Standard Plan or SMP coverage who become enrolled in Medicare Parts A and B will automatically be moved to the Medicare Plus plan. All other non-Medicare family members will remain covered under the Standard Plan or SMP.

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Choose Your Health Plan

HEALTH PLAN MAP 2013

The map on the following page shows which health plans are available in each county. “Qualified” plans are highlighted in underlined, bold text. If a plan is “non-qualified,” it has limited provider availability in that area.

The Standard Plan and Medicare Plus are available everywhere. As such, they don’t appear on this map.

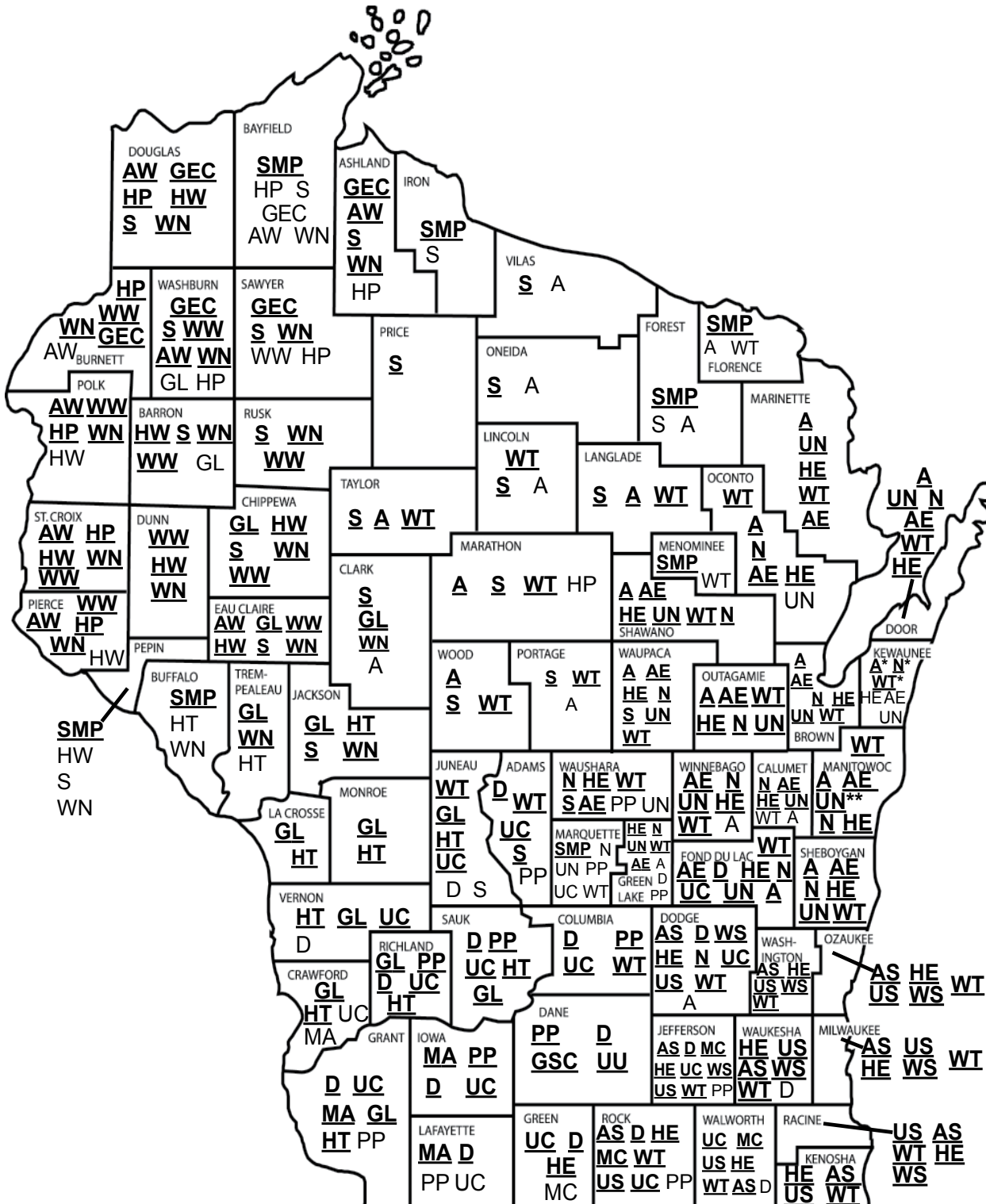
Health plan codes used on the map are explained in the chart on this page.

Plan specific information is available on the *Health Plan Description* pages later in this Guide.

Plan Codes	
Anthem Blue - Northeast	AE
Anthem Blue - Northwest	AW
Anthem Blue - Southeast	AS
Arise Health Plan	A
Dean Health Plan	D
Group Health Cooperative of Eau Claire	GEC
GHC of South Central Wisconsin	GSC
Gundersen Lutheran Health Plan	GL
Health Tradition Health Plan	HT
HealthPartners	HP
Humana - Eastern	HE
Humana - Western	HW
Medical Associates Health Plan	MA
Medicare Plus	N/A
MercyCare Health Plans	MC
Network Health Plan	N
Physicians Plus	PP
Security Health Plan	S
Standard Plan	N/A
State Maintenance Plan	SMP
UnitedHealthcare of Wisconsin NE	UN
UnitedHealthcare of Wisconsin SE	US
Unity - Community	UC
Unity - UW Health	UU
WEA Trust PPO - East	WT
WEA Trust PPO - Northwest	WN
WPS Metro Choice Northwest	WW
WPS Metro Choice Southeast	WS



HEALTH PLAN MAP 2013



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COMPARISON OF BENEFIT OPTIONS



The charts on the following pages are designed to compare Uniform Benefits, the Standard Plan and the Medicare Plus plan. There are differences in coinsurance between the Uniform Benefits for participants for whom Medicare is the primary payor and Uniform Benefits for non-Medicare plans.

The outlines are not intended to be a complete description of coverage. The Uniform Benefits package is described in detail in your *It's Your Choice: Reference*

Guide. Details for the other plans are found in the *Medicare Plus* (ET-4113) and *Standard Plan* (ET-2112) benefit booklets.

Differences might exist among the health plans in the administration of the Uniform Benefits packages. Slight differences may also exist in benefits such as dental or wellness programs, and treatment may vary depending on patient needs, the physicians' preferred practices, and the managed care policies and procedures of the health plan.

Note: Footnotes below refer to the chart on the following pages.

¹ Deductible applies to all services, except prescription drugs.

² PPOs have out-of-network deductibles. See PPO Plan Descriptions (WEA Trust PPOs and WPS Metro Choice) for details.

³ Coinsurance applies to all services up to the listed out-of-pocket limit (OOPL), then all services are covered at 100%.

⁴ PPOs have out-of-network coinsurance. See *Health Plan Descriptions* for detail.

⁵ As required by federal law, see list at: <http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html>. Note: coinsurance may vary by age.

⁶ This is separate from other out-of-pocket limits (OOPL), such as the medical.

⁷ Level 3 copays do not apply to the OOPL.

⁸ Medicare Plus supplements Medicare's payment up to 100% coverage. If Medicare denies, this plan also denies except as stated.

Choose Your Health Plan

2013 State—Comparison of Benefit Options

BENEFIT	UNIFORM BENEFITS FOR ELIGIBLE PARTICIPANTS WHO ARE NOT ELIGIBLE FOR NOR ENROLLED IN MEDICARE AS THE PRIMARY PAYOR	UNIFORM BENEFITS FOR RETIRED PARTICIPANTS FOR WHOM MEDICARE IS THE PRIMARY PAYOR
Annual Deductible ¹	No deductible ²	No deductible ²
Annual Coinsurance ³ & Out-of-Pocket Limit (OOPL)	90%/10% to annual OOPL \$500 individual/\$1,000 family except as described ⁴	As described in this grid and the one on the following page
Routine Preventive	100% ⁵	100%
Hospital Days	90%/10% coinsurance to OOPL as medically necessary, plan providers only. No day limit	100% as medically necessary, plan providers only. No day limit
Emergency Room	\$75 copay per visit, 90%/10% coinsurance thereafter to OOPL	\$60 copay per visit
Ambulance	90%/10% coinsurance to OOPL	100%
Transplants (May cover these and others listed)	90%/10% coinsurance to OOPL. <i>Bone marrow, parathyroid, musculoskeletal, corneal, kidney, heart, liver, kidney/pancreas, heart/lung, and lung</i>	100% <i>Bone marrow, parathyroid, musculoskeletal, corneal, kidney, heart, liver, kidney/pancreas, heart/lung, and lung</i>
Mental Health/Alcohol & Drug Abuse	90%/10% coinsurance to OOPL Inpatient, Outpatient & Transitional	100% Inpatient, Outpatient & Transitional
Hearing Exam	90%/10% coinsurance to OOPL	100%
Hearing Aid (per ear)	Every three years: Adults, 80%/20%, up to plan paid \$1,000; dependents younger than 18 years, 90%/10% to OOPL	Every three years: Adults, 80%/20%, up to plan paid \$1,000; dependents younger than 18 years, 100%
Cochlear Implants	Adults, 80%/20% for device, surgery for implantation, follow-up sessions; 90%/10% hospital charge for surgery. Dependents under 18, 90%/10% coinsurance up to OOPL for all services	Adults, 80%/20% for device, surgery for implantation, follow-up sessions; 100% hospital charge. Dependents under 18, 100%.

Footnotes explained on the preceding page.

2013 State—Comparison of Benefit Options

BENEFIT	UNIFORM BENEFITS FOR ELIGIBLE PARTICIPANTS WHO ARE NOT ELIGIBLE FOR NOR ENROLLED IN MEDICARE AS THE PRIMARY PAYOR	UNIFORM BENEFITS FOR RETIRED PARTICIPANTS FOR WHOM MEDICARE IS THE PRIMARY PAYOR
Routine Vision Exam	90%/10% coinsurance to OOPL for all members except 100% for children under age 5 ⁵	100%, one per year
Skilled Nursing Facility (non-custodial care)	90%/10% coinsurance to OOPL, 120 days per benefit period	100%, 120 days per benefit period
Home Health (non-custodial)	90%/10% coinsurance to OOPL, 50 visits per year. Plan may approve an additional 50	100%, 50 visits per year. Plan may approve an additional 50
Physical/Speech /Occupational Therapy	90%/10% coinsurance to OOPL, 50 visits per year. Plan may approve an additional 50	100%, 50 visits per year. Plan may approve an additional 50
Durable Medical Equipment	80%/20% coinsurance to OOPL	80%/20% coinsurance to annual \$500 OOPL per individual
Hospital Pre-Certification	Varies by plan	Varies by plan
Referrals	In-network—varies by plan Out-of-network—required	In-network—varies by plan Out-of-network—required
Treatment for Morbid Obesity	Excluded	Excluded
Oral Surgery	90%/10% coinsurance to OOPL, 11 procedures	100%, 11 procedures
Dental Care	Varies by plan	Varies by plan
Drug Copays and OOPL ⁶ (non-specialty)	Level 1=\$5; 2=\$15; 3=\$35 ⁷ . OOPL \$410 individual/\$820 family	Level 1=\$5; 2=\$15; 3=\$35 ⁷ . OOPL \$410 individual/\$820 family
Specialty Drug Copays and OOPL ⁶ - Preferred Pharmacy	Formulary drugs \$15 to OOPL \$1,000 individual/\$2,000 family. Non-formulary drugs \$50, no OOPL	Formulary drugs \$15 to OOPL \$1,000 individual/\$2,000 family. Non-formulary drugs \$50, no OOPL
Specialty Drug Copays and OOPL ⁶ - Non-Preferred Pharmacy	Formulary drugs \$50 to OOPL \$1,000 individual/\$2,000 family. Non-formulary drugs \$50, no OOPL	Formulary drugs \$50 to OOPL \$1,000 individual/\$2,000 family. Non-formulary drugs \$50, no OOPL

Choose Your Health Plan

2013 State—Comparison of Benefit Options

BENEFIT	STANDARD PLAN		MEDICARE PLUS and Medicare Part A, B and D ⁸
	Preferred Provider	Non-Preferred Provider	
Annual Deductible ¹	\$200 individual/ \$400 family	\$500 individual/ \$1,000 family	No deductibles
Annual Coinsurance ³ & OOP	90%/10% Annual OOP (<i>includes deductible</i>): \$800 individual/\$1,600 family	70%/30% Annual OOP (<i>includes deductible</i>): \$2,000 individual/\$4,000 family	100%
Routine Preventive	100% ⁵	Deductible and coinsurance	100% Covered by Medicare only
Hospital Days	Deductible and coinsurance as medically necessary, no day limit	Deductible and coinsurance as medically necessary, no day limit	100% 120 days; semi-private room
Emergency Room	\$75 copay per visit, deductible and coinsurance thereafter	\$75 copay per visit, Preferred Provider deductible and coinsurance thereafter	100% no copay
Ambulance	Deductible and coinsurance	Deductible and coinsurance	100%
Transplants (<i>May cover these and others listed</i>)	Deductible and coinsurance <i>Bone marrow, musculoskeletal, corneal, and kidney</i>	Deductible and coinsurance <i>Bone marrow, musculoskeletal, corneal, and kidney</i>	100% for Medicare approved heart, lung, kidney, pancreas, intestine, bone marrow, cornea, and liver transplants in a Medicare-certified facility
Mental Health/ Alcohol & Drug Abuse	Deductible and coinsurance	Deductible and coinsurance	Inpatient 100%, up to 120 days Outpatient & Transitional 100%
Hearing Exam	Benefit for illness or disease to deductible and coinsurance	Benefit for illness or disease to deductible and coinsurance	Benefit for illness or disease 100%
Hearing Aid (per ear)	For dependents younger than 18 years only, every three years—deductible and coinsurance	For dependents younger than 18 years only, every three years—deductible and coinsurance	For dependents younger than 18 years only, every three years—100%
Cochlear Implants	Dependents under 18, deductible and coinsurance device, surgery, follow-up sessions	Dependents under 18, deductible and coinsurance device, surgery, follow-up sessions	Dependents under 18, 100% device, surgery, follow-up sessions

Footnotes explained on Page 27.

2013 State—Comparison of Benefit Options

BENEFIT	STANDARD PLAN		MEDICARE PLUS and Medicare Part A, B and D ⁸
	Preferred Provider	Non-Preferred Provider	
Routine Vision Exam	100% for children under age 5 ⁵ . Illness or disease only, deductible and coinsurance	No benefit for routine. Illness or disease only, deductible and coinsurance	No benefit for routine. Illness or disease only, 100%
Skilled Nursing Facility (non-custodial care)	Deductible and coinsurance, as medically necessary, 120 days per benefit period	Deductible and coinsurance, as medically necessary, 120 days per benefit period	Medicare approved facility: 100% 120 days/benefit period. Non-Medicare approved facility, if transferred within 24 hours of hospital release, benefits payable up to 30 days/ confinement
Home Health (non-custodial)	Deductible and coinsurance, 50 visits per plan year. Plan may approve an additional 50	Deductible and coinsurance, 50 visits per plan year. Plan may approve an additional 50	100%
Physical/Speech/ Occupational Therapy	Deductible and coinsurance, 50 visits per plan year. Plan may approve an additional 50	Deductible and coinsurance, 50 visits per plan year. Plan may approve an additional 50	100%,
Durable Medical Equipment	Deductible and coinsurance	Deductible and coinsurance	100%
Hospital Pre-Certification	WPS Medical Management Program for inpatient stays	WPS Medical Management Program for inpatient stays	None required
Treatment for Morbid Obesity	Preferred provider deductible and coinsurance at Centers of Excellence provider	Non-preferred provider deductible and coinsurance outside Centers of Excellence provider	100% for Medicare covered service
Oral Surgery	23 procedures—deductible and coinsurance	23 procedures— deductible and coinsurance	100%
Dental Care	No benefit	No benefit	No benefit
Drug Copays and OOPL ⁶ (non-specialty)	Level 1=\$5; 2=\$15; 3=\$35 ⁷ OOPL \$1,000 individual/ \$2,000 family	Level 1=\$5; 2=\$15; 3=\$35 ⁷ OOPL \$1,000 individual/ \$2,000 family	Level 1=\$5; 2=\$15; 3=\$35 ⁶ OOPL \$410 individual/\$820 family
Specialty Drug Copays and OOPL ⁶	Formulary drugs \$15 to OOPL \$1,000 individual/\$2,000 family. Non-formulary drugs \$50, no OOPL	Formulary drugs \$50 to OOPL \$1,000 individual/\$2,000 family. Non-formulary drugs \$50, no OOPL	Drugs at preferred pharmacy, see Preferred Provider column. Drugs at non-preferred pharmacy, see Non-Preferred Provider column

Footnotes explained on Page 27.

Choose Your Health Plan

HEALTH PLAN FEATURES — AT A GLANCE



Evaluate Your Health Plan Features and Take Charge of Your Health

On the surface, you may think that there is not much difference among the available health plan options. However, benefits and services can vary from plan to plan. The chart on the following pages was developed to assist you in comparing the health plans on key benefits and services.

Dental Benefits

The Uniform Benefits package does not include coverage for routine dental care, but the health plans have the option to offer dental coverage to members. The comparison chart highlights the plans that have elected to provide some level of dental coverage. Members who place a high value on dental services should refer to the additional information in the *Health Plan Descriptions* that appear later in this section or contact the health plan directly if you have specific questions regarding dental coverage or dental provider availability.

Quality

Each year, participating health plans are evaluated based on care delivery in areas such as wellness and prevention, disease management and consumer satisfaction. The chart lists how the various health plans rated on overall quality and how many of our members would recommend their plan to family and friends. We encourage you to also look at the more comprehensive quality ratings in the *Choose Quality* section of this book.

Health Plan Services

Some of the health plans have requirements and offer additional services to assist members. The chart lists which plans offer the following services.

- Selecting a **primary care physician (PCP)** or clinic location is strongly encouraged to provide you with

Choose Your Health Plan

coordinated care and is required by some health plans.

- **24-Hour Nurseline** is a help-line that is staffed by a registered nurse 24-hours a day to provide members with information and assessment of emerging medical needs. This is a useful resource in determining if you need to seek emergency or urgent care services, or if you have a medical question and are unable to reach your primary care physician.

Disease Management and Wellness Programs

Your daily decisions and actions can have a positive or negative impact on your overall health. The chart lists which plans offer the following services.

Health Risk Assessments (HRAs) with Biometric Screening are a great tool to help you assess your health history and lifestyle choices in order to identify certain characteristics that may, over time, develop into diseases such as cancer, diabetes, heart disease and osteoporosis. Once you have completed the HRA questionnaire, your health plan will provide you with personalized information to help you take charge of your health. All of the health plans offer incentives, such as gift cards, cash, etc., if you complete the HRA and/or participate in biometrics and the disease management and wellness programs they offer.

Wellness Programs may be offered by the health plans. These services may be in the form of online

educational tools, organized programs/ classes through providers, health club memberships, and/or discounts to participate in various wellness activities.

Disease Management Programs may be offered by the health plans. These programs are for members with chronic health conditions and are designed to provide education and enhance the regular treatment of diseases or conditions.

Online Services

If you have Internet access, some health plans offer online information and services on their websites. Some areas of these websites may require members to enroll to gain access using a specified login identification and password. The chart lists some of the services various plans offer, such as searchable provider directories and access to your medical information.



Health Plan Features – At a Glance

Stars: ★ 1-4, one being lowest

<ul style="list-style-type: none"> Indicates a “Yes” response. This means the health plan either offers the service or has a requirement that applies. 	Quality Information			Dental Benefits			
	Overall Quality Score	% Would Recommend Plan to Family or Friends	NQQA Accreditation	Copay/ Deductible Applies	Orthodontic Benefits	Annual Benefit Maximum per Member	Separate Dental ID Card Required
Anthem Blues*	★★	88%	●		●		
Arise Health Plan	★★★	95%	●	●	●	●	●
Dean Health Plan	★★★	97%	●	●	●	●	●
GHC of Eau Claire	★★★	93%			●		
GHC of South Central Wisconsin	★★★★	95%	●		●		
Gundersen Lutheran Health Plan	★★★	95%	●			●	
Health Tradition Health Plan	★★★	94%				●	
HealthPartners	★★★	93%	●		●		●
Humana - Eastern	★	88%	●	●	●		●
Humana - Western	★	84%	●	●	●		●
Medical Associates	★★★	94%	●	●	●	●	
MercyCare Health Plans	★★★	91%	●	●	●	●	●
Network Health Plan	★★★	96%	●	●	●	●	●
Physicians Plus	★★★	95%	●		●		
Security Health Plan	★★★	96%	●	●	●	●	
State Maintenance Plan	Not available	69%		No dental coverage available.			
UnitedHealthcare NE	★	93%	●	●	●	●	●
UnitedHealthcare SE	★★	95%	●	●	●	●	●
Unity - Community	★★★	95%	●		●	●	●
Unity - UW Health	★★★	95%	●		●	●	●
WEA Trust PPO - East & Northwest	★(East Only**)	97% (East Only)			●	●	
WPS Metro Choice - Northwest & Southeast	Not available	92% (SE Only)		●	●	●	●

*All three Anthem health plans were combined into Anthem Blues for the purpose of calculating the composite scores.

**Overall quality score is not available for WEA Trust PPO - Northwest.

Health Plan Features – At a Glance

<ul style="list-style-type: none"> Indicates a “Yes” response. This means the health plan either offers the service or has a requirement that applies. 	Health Plan Services		Online Services			
	Clinic Required Primary Care Physician or	24-hour Nurseline Offered	Searchable Provider Directory	Member Service Messaging Center	View Appointments and Review	View Electronic Health Records
Anthem Blues*		•	•	•		•
Arise Health Plan	•		•	•		
Dean Health Plan	•	•	•	•	•	•
GHC of Eau Claire	•	•				
GHC of South Central Wisconsin	•	•	•	•	•	•
Gundersen Lutheran Health Plan		•	•	•	•	•
Health Tradition Health Plan	•	•	•			
HealthPartners		•	•	•	•	•
Humana - Eastern	•	•	•	•		•
Humana - Western	•	•	•	•		•
Medical Associates		•	•	•	•	
MercyCare Health Plans		•	•	•	•	•
Network Health Plan	•	•	•	•		
Physicians Plus	•	•	•	•	•	•
Security Health Plan	•	•	•			
State Maintenance Plan			•	•		
UnitedHealthcare NE		•			•	•
UnitedHealthcare SE		•			•	•
Unity - Community	•		•	•	•	•
Unity - UW Health	•		•	•	•	•
WEA Trust PPO - East & Northwest			•			
WPS Metro Choice - Northwest & Southeast			•	•		

Health Plan Features – At a Glance

<ul style="list-style-type: none"> Indicates a “Yes” response. This means the health plan offers the service. O=Online, T=Telephone, P=Paper 	Wellness Programs**			Disease Management Programs**			
	Health Risk Assessment (HRAs) and Biometrics	Smoking Cessation	Weight Management	Asthma Management	Lower Back Core Management	Diabetes Core Management	Prenatal and Postnatal Programs
Anthem Blues*	○	●	●	●		●	●
Arise Health Plan	O, P, T	●				●	●
Dean Health Plan	○	●	●	●		●	●
GHC of Eau Claire	○	●		●		●	●
GHC of South Central Wisconsin	O, P	●	●	●	●	●	●
Gundersen Lutheran Health Plan	○	●	●	●		●	
Health Tradition Health Plan	○	●		●	●	●	●
HealthPartners	○	●	●	●		●	●
Humana - Eastern	○	●	●	●	●	●	●
Humana - Western	○	●	●	●	●	●	●
Medical Associates	○	●	●	●	●	●	●
MercyCare Health Plans	O, P	●	●	●		●	●
Network Health Plan	○	●	●	●		●	●
Physicians Plus	○	●	●			●	●
Security Health Plan	○	●	●	●	●	●	●
State Maintenance Plan	O, P			●		●	●
UnitedHealthcare NE	○	●	●	●		●	●
UnitedHealthcare SE	○	●	●	●		●	●
Unity - Community	○	●	●	●	●	●	●
Unity - UW Health	○	●	●	●	●	●	●
WEA Trust PPO - East & Northwest	○	●	●	●	●	●	●
WPS Metro Choice - Northwest & Southeast	O, P			●		●	●

*All three Anthem health plans were combined into Anthem Blues for the purpose of calculating the composite scores.

**Plans may offer incentives, discounts and/or reimbursements for participation. Check with the health plan for details.

Anthem Blue Preferred – Northeast Network

(866) 593-3085 from Oct. 1 to Nov. 5, 2012

(800) 490-6201 after Nov. 5 (Non-members, choose "1", "0#", "0#" from menu)
anthem.com



Overall Quality Rating

See Report Card section

What's New for 2013

We are excited to announce that, with enhancements to our network of dental providers, we are now qualified in 14 counties.

As of January, incentives of \$150 are available for members who complete their biometric screenings and Anthem's online health assessment. Contact Anthem customer service for details on how to earn this!

Provider Directory

To access the directory, go to **anthem.com/stateofwisconsin**. You may also call Anthem customer service to request a paper copy.

Referrals and Prior Authorizations

You don't need a referral when you see a specialist in the Northeast Network. If the specialist isn't in the network, you'll need a written referral from your primary care physician (PCP) and authorization from Anthem. This plan will pay some or all of the costs to see a specialist for covered services only if you have the plan's permission before you see the specialist. You will need prior authorization for some medical procedures. Your PCP or specialist will initiate this. You also need precertification for non-emergency hospital stays.

Care Outside Service Area

For emergency care, go to the nearest health care facility. Contact your PCP and Anthem within 24 hours or as soon as possible. For urgent care, call your PCP for advice on the right treatment. All other services must be received within your service area.

Mental and Behavioral Health Services

You don't need a referral to see a Northeast Network mental health provider. You will need precertification for inpatient care.

Dental Benefits (Contact plan for full details.)

Preventive Services:

100% coverage:

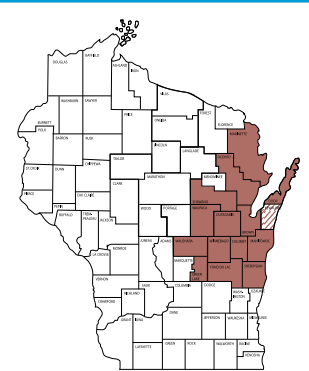
Comprehensive, periodic exams; diagnostic X-rays and necessary preventive cleanings every six months; Fluoride treatments for children under 12.

NEW Restorative Services: Covered at 50% after deductible (\$50 per individual/\$150 per family) for amalgam fillings.

NEW Annual Benefit Maximum: \$500 per individual.

NEW Orthodontics: Covered at 50% not subject to deductible for dependents younger than age 19 up to a lifetime maximum of \$500 per individual.

NEW Dental Network: You are free to use any dentist; however, you will not be balance-billed for services by a network provider. Please see Anthem's directory for network listings.



■ Qualified Plan
▨ Non-Qualified Plan
See Glossary for definitions

Health Risk Assessment Information for Enrolled Members at:
anthem.com/health-insurance/health-and-wellness/hw-overview

Anthem Blue Preferred – Northwest Network

(866) 593-3085 from Oct. 1 to Nov. 5, 2012

(800) 490-6201 after Nov. 5 (Non-members, choose "1", "0#", "0#" from menu)

anthem.com



Overall Quality Rating

See Report Card section

What's New for 2013

We are excited to announce that, with enhancements to our network of dental providers, eight of our nine offered counties are now qualified.

As of January, incentives of \$150 are available for members who complete their biometric screenings and Anthem's online health assessment. Contact Anthem customer service for details on how to earn this!

Provider Directory

To access the directory, go to anthem.com/stateofwisconsin. You may also call Anthem customer service to request a paper copy.

Referrals and Prior Authorizations

You don't need a referral when you see a specialist in the Northwest Network. If the specialist isn't in the network, you'll need a written referral from your primary care physician (PCP) and authorization from Anthem. This plan will pay some or all of the costs to see a specialist for covered services only if you have the plan's permission before you see the specialist. You will need prior authorization for some medical procedures. Your PCP or specialist will initiate this. You also need precertification for non-emergency hospital stays.

Care Outside Service Area

For emergency care, go to the nearest health care facility. Contact your PCP and Anthem within 24 hours or as soon as possible. For urgent care, call your PCP for advice on the right treatment. All other services must be received within your service area.

Mental and Behavioral Health Services

You don't need a referral to see a Northwest Network mental health provider. You will need precertification for inpatient care.

Dental Benefits (Contact plan for full details.)

Preventive Services:

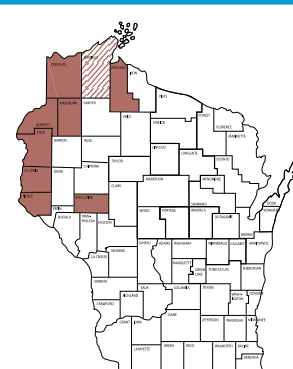
100% coverage:
Comprehensive,
periodic exams; diagnostic X-rays and necessary preventive cleanings every six months; Fluoride treatments for children under 12.

NEW Restorative Services: Covered at 50% after deductible (\$50 per individual/\$150 per family) for amalgam fillings.

NEW Annual Benefit Maximum: \$500 per individual.

NEW Orthodontics: Covered at 50% not subject to deductible for dependents younger than age 19 up to a lifetime maximum of \$500 per individual.

NEW Dental Network: You are free to use any dentist; however, you will not be balance-billed for services by a network provider. Please see Anthem's directory for network listings.



■ Qualified Plan
▨ Non-Qualified Plan
See Glossary for definitions

Health Risk Assessment Information for Enrolled Members at:
anthem.com/health-insurance/health-and-wellness/hw-overview

Anthem Blue Preferred – Southeast Network

(866) 593-3085 from Oct. 1 to Nov. 5, 2012

(800) 490-6201 after Nov. 5 (Non-members, choose "1", "0#", "0#" from menu)
anthem.com



Overall Quality Rating

See Report Card section

What's New for 2013

We are excited to announce that, with enhancements to our dental network of providers, Walworth is now a qualified county.

As of January, incentives of \$150 are available for members who complete their biometric screenings and Anthem's online health assessment. Contact Anthem customer service for details on how to earn this!

Provider Directory

To access the directory, go to **anthem.com/stateofwisconsin**. You may also call Anthem's customer service to request a paper copy.

Referrals and Prior Authorizations

You don't need a referral when you see a specialist in the Southeast Network. If the specialist isn't in the network, you'll need a written referral from your primary care physician (PCP) and authorization from Anthem. This plan will pay some or all of the costs to see a specialist for covered services only if you have the plan's permission before you see the specialist. You will need prior authorization for some medical procedures. Your PCP or specialist will initiate this. You also need precertification for non-emergency hospital stays.

Care Outside Service Area

For emergency care, go to the nearest health care facility. Contact your PCP and Anthem within 24 hours or as soon as possible. For urgent care, call your PCP for advice on the right treatment. All other services must be received within your service area.

Mental and Behavioral Health Services

You don't need a referral to see a Southeast Network mental health provider. You will need precertification for inpatient care.

Dental Benefits (Contact plan for full details.)

Preventive Services:

100% coverage:
Comprehensive, periodic exams; diagnostic X-rays and necessary preventive cleanings every six months; Fluoride treatments for children under 12.

NEW Restorative Services: Covered at 50% after deductible (\$50 per individual/\$150 per family) for amalgam fillings.

NEW Annual Benefit Maximum: \$500 per individual.

NEW Orthodontics: Covered at 50% not subject to deductible for dependents younger than age 19 up to a lifetime maximum of \$500 per individual.

NEW Dental Network: You are free to use any dentist; however, you will not be balance-billed for services by a network provider. Please see Anthem's directory for network listings.



Health Risk Assessment Information for Enrolled Members at:
anthem.com/health-insurance/health-and-wellness/hw-overview

Arise Health Plan

(888) 711-1444 toll free or (920) 490-6900
wecareforwisconsin.com

★★★★☆
Overall Quality Rating
See Report Card section

What's New for 2013

Arise Health Plan now has a fresh new look! We have updated our logo to a sleeker, more modern design. Check out our new logo and other exciting design changes when viewing our website.

Arise Health Plan is now offering \$150 toward a health club membership of your choice for each adult Arise member who completes a health risk assessment (HRA)/biometric screening.

Provider Directory

Go to **wecareforwisconsin.com**, select **Members** and then **Find A Doctor**. Enter group number "087889." To print a provider directory, scroll to the bottom of the **Find A Doctor** page and **select the link below the search options**, or call (888) 711-1444 to request a directory.

Referrals and Prior Authorizations

No written referrals are required when receiving necessary care from participating providers. Pre-service authorization is required for all non-participating providers and tertiary-care specialists and facilities. Arise Health Plan will send written notification of approval or denial to you and your provider requesting the pre-service authorization.

Care Outside Service Area

Emergency care is covered. If you are admitted to the hospital, you must notify Arise within 48 hours. If you are out of area and need urgent care, go to the nearest appropriate facility, unless you can safely return to the service area to receive care from a participating provider. For follow-up care, contact your PCP for instructions.

Mental and Behavioral Health Services

Participating providers must be used for all mental health, alcohol and other drug abuse (AODA) services.

Pre-service authorization is required for inpatient services and transitional care; however, it is not required for outpatient care.

Dental Benefits (Contact plan for full details.)

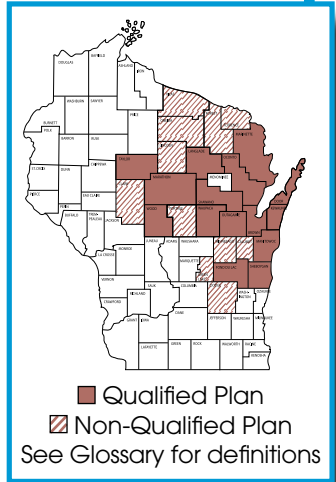
Preventive Services: Covered at 100%: Exams, cleanings, fluoride treatments, X-rays, space maintainers. Limited to six-month intervals. Full mouth X-rays.

Restorative Services: Covered at 80%, subject to deductible (\$25 individual/\$75 family): Sealants (up to age 14, one per tooth per lifetime), fillings, and emergency treatment to relieve pain.

Annual Benefit Maximum: Individual maximum is \$1,000.

Orthodontics: 50% for eligible dependent children up to a lifetime maximum of \$1,500.

Dental Network: Dental benefits are administered by Delta Dental. Go to **deltadentalwi.com** and select **Premier** or **PPO** as your dental plan. Call (800) 236-3712 with questions.



Health Risk Assessment Information for Enrolled Members:
Contact Member Services at (920) 490-6900

Dean Health Plan Inc.

(800) 279-1301

deancare.com/wi-employees



Overall Quality Rating

See Report Card section

What's New for 2013

Dean Health Plan's (DHP) approach to prevention and health promotion is integrated into our overall medical management program. In the fall of 2012, we will launch DHP's Living Healthy Program, which provides a suite of wellness and disease management offerings. To help identify and address health risks, members may access an online Well Being Assessment portal. Members are encouraged to use these tools to identify personal areas of risk and take actions to address them. DHP also offers members the opportunity to obtain a cash incentive by completing the Well Being Assessment. For complete details, visit deancare.com/wi-employees.

Provider Directory

Go to deancare.com/wi-employees. For a searchable directory, select **Online Provider Directory**. For a PDF directory, select **Printable Provider Directory**. You may also call the Customer Care Center to request a copy.

Referrals and Prior Authorizations

Referrals are not needed when receiving care from plan providers. Prior authorizations are required for certain services and care from all non-plan providers. If you are unsure if a service or procedure requires prior authorization, contact the Customer Care Center. You must tell your provider to contact DHP for an approved prior authorization before receiving care. DHP will notify you and your provider in writing of the decision.

Care Outside Service Area

When you receive emergency or urgent care outside the DHP network, call the number on your ID card by the next business day or as soon as possible. Non-emergency/urgent

care is not covered unless an approved prior authorization is obtained.

Mental and Behavioral Health Services

You can see any plan provider for mental and behavioral health services. Inpatient mental health must be prior authorized.

Ameritas Group Dental Benefits (Contact plan for full details.)

Preventive Services: Covered at 100% in-network, subject to office visit copay when using out-of-network providers. Exams, cleanings and bite-wing X-rays two per year.

Restorative Services: Covered at 80% in-network, subject to office visit copay when using out-of-network providers. Sealants (age 14 and under), restorative amalgams, restorative composites.

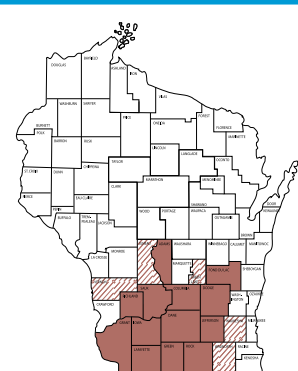
Annual Benefit Maximum: \$1,500/individual in-network or \$1,000/individual out-of-network. The maximum amounts are a combined benefit.

Office Visit Copay: \$0 network provider; \$40 per visit with out-of-network provider.

Deductible: \$0.

Orthodontics: 50% for dependents younger than age 19, up to an individual lifetime maximum of \$1,750.

Dental Network: You may use any dental provider. Usual and customary charges may apply when using an out-of-network provider. See the Provider Directory section at left to find a provider.



■ Qualified Plan
▨ Non-Qualified Plan
See Glossary for definitions

Health Risk Assessment Information for Enrolled Members at:
deancare.com/deanconnect

Group Health Cooperative of Eau Claire

(888) 203-7770 or (715) 552-4300

group-health.com



Overall Quality Rating

See Report Card section

What's New for 2013

Group Health Cooperative of Eau Claire has added new online applications which include Wiser Health. This tool contains detailed health information on more than 200 health conditions including examples of what doctors who have those conditions do for diagnosis and treatment.

New in 2013, Group Health Cooperative of Eau Claire will have health promotion coaches available at work sites in our coverage area for biometric screenings and coaching sessions. All members who complete this voluntary process will be entered into a prize drawing. Details will be available online at **group-health.com**.

Provider Directory

Refer to our website **group-health.com** and choose **Find a Provider** to access the **2013 State of WI** provider listing.

Referrals and Prior Authorizations

Referrals are not required for in-network providers. Prior to receiving care from an out-of-network provider, you must get a referral event authorization. Event authorization is required for all admissions, selected outpatient services and all out-of-network care. **For certain procedures, members will be required to participate in a patient decision aid program to review information on options, outcomes and to clarify personal values.** Group Health Cooperative will send written notification to you and the ordering physician of approval or denial of the event authorization request. For further information regarding authorization guidelines please visit **group-health.com** or call (888) 203-7770 to speak with a member services advocate.

Care Outside Service Area

Emergency and urgent care do not require a referral. The FirstCare Nurseline, listed on your ID card, can help you determine the appropriate level of care. Group Health Cooperative has the right to review for medical necessity. Follow up care must be received by an in-network provider.

Mental and Behavioral Health Services

No referral is needed to see a provider in Group Health Cooperative's network. Please refer to the Provider Directory for a listing of mental health providers in Group Health Cooperative's network.

Dental Benefits (*Contact plan for full details.*)

Preventive Services: Covered at 100%:

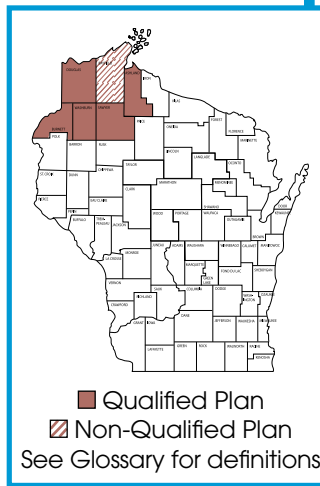
Routine exams and cleanings (twice a year), fluoride treatments, routine X-rays and sealants.

Restorative Services: None

Annual Benefit Maximum: None

Orthodontics: 50% for dependents through age 18, up to an individual lifetime maximum of \$1,200.

Dental Network: Call member services at (888) 203-7770 or go to **group-health.com** and choose **Find a Provider** to access the **2013 State of WI** provider listing.



Health Risk Assessment Information for Enrolled Members:
Contact a member services advocate at (888) 203-7770

Group Health Cooperative of South Central Wisconsin

(608) 828-4853 or (800) 605-4327, ext. 4504
ghcscw.com



Overall Quality Rating

See Report Card section

What's New for 2013

- New wellness reimbursements for Madison School and Community Recreation (MSCR) fitness classes.
- Check out our new complementary medicine classes and services including aromatherapy sessions and Walking Thai Massage.
- GHCNurseConnect, 24-hour nurse advice line.

Provider Directory

Visit https://ghcscw.com/Advanced_Search.asp to search for providers and to view their professional qualifications. Members may request a provider directory from GHC-SCW member services at (800) 605-4327, ext. 4504.

Referrals and Prior Authorizations

Your primary care physician will submit a referral request to a certified GHC-SCW case manager when you need to receive services outside of a GHC-SCW clinic or through a specialty care area. You will receive a letter from GHC-SCW, as well as notification in your GHCMYChart online account, letting you know if the referral request has been approved.

Care Outside Service Area

Call GHC-SCW at (800) 605-4327, ext. 4504 within 48 hours after receiving emergency or urgent care outside the GHC-SCW network. All other care requires a referral as described above. This phone number is also located on the member ID card.

Mental and Behavioral Health Services

When you need mental health services, contact a GHC-SCW staff outpatient mental health provider directly. Please refer to the GHC-SCW Provider Directory. A referral is *not* required for services provided in a GHC-SCW clinic. A referral *is* needed for transitional and/or inpatient care.

Dental Benefits (See plan for full details.)

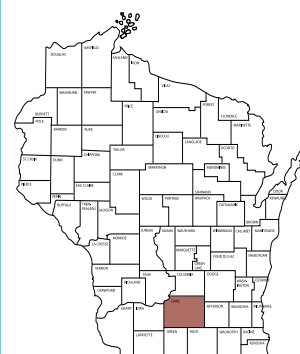
Preventive Services: Covered at 100%:
Exams, X-rays, cleanings, every six months.

Restorative Services: Covered at 100%:
Amalgam fillings, composite fillings for anterior teeth, stainless steel crowns for primary teeth and simple and surgical extractions.

Annual Benefit Maximum: None.

Orthodontics: 50% of the first \$3,500 in billed charges for dependent children through age 18.

Dental Network: All dental services must be obtained from Dental Health Associates in Madison.



■ Qualified Plan
▨ Non-Qualified Plan
See Glossary for definitions

Health Risk Assessment Information for Enrolled Members at:
ghcscw.com

Gundersen Lutheran Health Plan

(800) 897-1923 or (608) 775-8007

glhealthplan.org



Overall Quality Rating

See Report Card section

What's New for 2013

Gundersen Lutheran Health Plan (GLHP) wants you to have up-to-date test results to help you and your healthcare provider make decisions about your care. In 2013, GLHP will offer an incentive to adult members who complete an online health assessment, as well as health screenings. Screenings will include fasting glucose, cholesterol, blood pressure and body mass index (height and weight). Did you know, GLHP ranked in the Top 100 health plans in the country by the National Committee for Quality Assurance (NCQA)?

Provider Directory

To view or print a copy of the provider directory, go to glhealthplan.org/etf; click on **2013 Provider Directory**. To access the most current practitioners and facilities, a searchable online directory is also available at glhealthplan.org/providerdirectory. You may also call customer service at (800) 897-1923 or (608) 775-8007 to request a provider directory or to find a provider in your network.

Referrals and Prior Authorizations

A member may seek services from any GLHP network provider without a referral. If your GLHP provider feels that you require specialty care outside of the network, he/she must complete a referral request form and submit it to GLHP. Selected medical procedures and services, including high-tech radiology and low back surgery, require prior authorization. Your provider should submit a written prior authorization request to GLHP. GLHP will respond in writing to you and your provider after reviewing the referral or prior authorization request.

Care Outside Service Area

In the case of an emergency or urgent medical condition, you should seek care from the nearest provider equipped to handle your condition. You must receive urgent care from a plan provider if you are in the plan service area, unless it is not reasonably possible.

Please notify GLHP within 24 hours if admitted to a hospital. All other care must be with a plan provider, unless GLHP has approved a referral as described above.

Mental and Behavioral Health Services

Referrals are not required for services received from a GLHP behavioral health provider. Prior authorization is required for transitional services.

Dental Benefits (See plan for full details.)

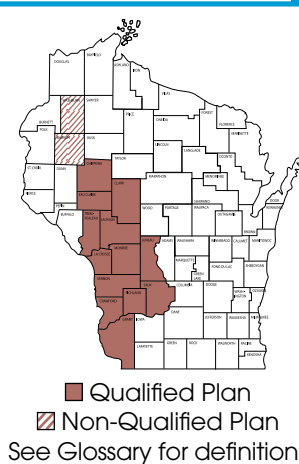
Preventive Services: Covered at 100%: Exams, prophylaxis, fluoride (to age 18), sealants (to age 18) and X-rays, two per calendar year, subject to the \$500 annual benefit maximum.

Restorative Services: Covered at 80%: Bridgework, implants, dentures, crowns and root canals.

Annual Benefit Maximum: \$500 per person per calendar year.

Orthodontics: None.

Dental Network: You can go to any dental provider and the services are not subject to a usual and customary fee schedule.



Health Risk Assessment Information for Enrolled Members at:
glhealthplan.org/assessment

Health Tradition Health Plan

(877) 832-1823 or (888) 459-3020

healthtradition.com



Overall Quality Rating

See Report Card section

What's New for 2013

The Health Tradition Health Plan (HTHP) website, **healthtradition.com**, was recently redesigned to offer more functionality and helpful resources for our members. Health Tradition members will also be able to access our Health Risk Assessment tool via our website. Please check the website periodically for additional details regarding health and wellness initiatives through Health Tradition. Continue to refer to the online provider directory to make sure the provider/facility you go to is in the HTHP network for the state of Wisconsin.

Provider Directory

Go to **healthtradition.com**. You can select **MMSI Service Center** in the bottom right section of the home page. Once you log in, click on **Find a Doctor** across the top tool bar. Select **MMSI** as your network and then you can do a provider search by provider name, specialty, location, etc. You can also contact HTHP at (888) 459-3020 to request a paper copy.

Referrals and Prior Authorizations

You can see any provider in the HTHP network (primary care or specialist) without a referral. You must get a referral approved by HTHP before you see providers outside the HTHP network (including Mayo Clinic-Rochester). Your doctor must submit a referral request. Prior authorization is required for certain services. Contact HTHP to request a prior authorization. HTHP will notify you and your provider in writing as to whether the request has been approved or denied. For more information, see the HTHP website or call HTHP at (877) 832-1823.

Care Outside Service Area

Call us at (888) 758-7848 within 48 hours after receiving emergency or urgent care outside of the HTHP network. All other care requires HTHP approval as described above.

Mental and Behavioral Health Services

You must use a provider within the HTHP network for mental/behavioral health services. Prior authorization is required for inpatient care, group therapy and psychiatric testing.

Dental Benefits (*Contact plan for full details.*)

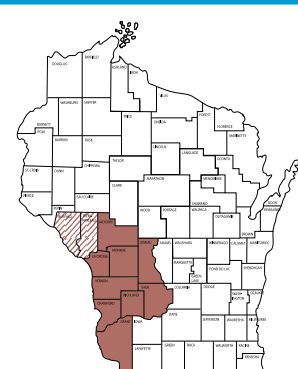
Preventive Services: Covered at 100% up to annual benefit maximum: Exams, cleanings, fluoride treatments, X-rays and sealants.

Restorative Services: Covered at 80%, up to annual benefit maximum: Services such as fillings, bridges, crowns and root canals.

Annual Benefit Maximum: \$500 per person per year on all services.

Orthodontics: None.

Dental Network: You can see any dentist. Benefits subject to usual and customary charges unless you use the Health Tradition Preferred Dental Network. To view our dental providers, go to **healthtradition.com** and click on **Provider Directory** across the top toolbar. Scroll down to the heading titled **State of Wisconsin Members** and select **Dental Provider Directory**.



■ Qualified Plan
▨ Non-Qualified Plan
See Glossary for definitions

Health Risk Assessment Information for Enrolled Members at:
<https://healthtradition.com/EmbodyHealth/>

HealthPartners Health Plan

(800) 883-2177 or (952) 883-5000

healthpartners.com/stateofwis



Overall Quality Rating

See Report Card section

What's New for 2013

HealthPartners is offering gift cards to members for taking an active role in their health. Participating in health assessments, biometric screenings and programs designed to improve your health can earn you gift cards! See our website for more information, at healthpartners.com/stateofwis. Virtuwell by HealthPartners is our 24/7 online clinic available to all Minnesota and Wisconsin residents. Visit the website at virtuwell.com to have your symptoms reviewed by a nurse practitioner for the diagnosis and treatment of up to 30 common medical conditions. As always, members can also register online to view claims, explanations of benefits and other personal health information.

Provider Directory

Go to healthpartners.com/stateofwis and click on the **find a doctor or specialist** link. Click on the **PDF listing** or search our online directory for providers. No registration is necessary. Search providers as well as facilities to make sure they are in our network. Call (800) 883-2177 to request a directory or for assistance in finding a provider.

Referrals and Prior Authorizations

No referrals are necessary to see in-network providers. Certain services will require a prior authorization. Call member services at (800) 883-2177 for more information see healthpartners.com/stateofwis. Your doctor will request the authorization, and HealthPartners will notify you in writing of the coverage decision.

Care Outside Service Area

Members are covered for emergency and urgently needed care outside of the HealthPartners plan service area when medically necessary. Call (800) 316-9807 within 48 hours if an admission occurs.

Mental and Behavioral Health Services

No referrals are necessary to see in-network behavioral health providers.

Dental Benefits (Contact plan for full details.)

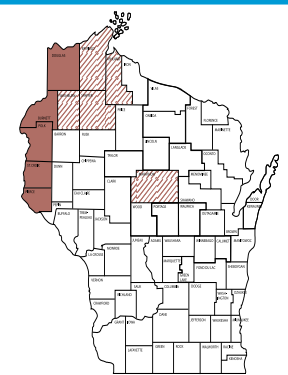
Preventive Services: Covered at 100%: Examinations, dental cleaning every six months, topical fluoride, sealants, bite-wing X-rays and full mouth panoramic X-rays (subject to limitations).

Restorative Services: None.

Annual Benefit Maximum: Unlimited for preventive services.

Orthodontics: Covered at 50% for children to age 19 up to a lifetime maximum of \$1,200; 20% discount available with some providers through HealthyDiscounts.

Dental Network: Go to healthpartners.com/stateofwis and click on the **search for providers** link. Coverage is available for out-of-network services, but charges are payable up to usual and customary levels.



■ Qualified Plan
▨ Non-Qualified Plan
See Glossary for definitions

Health Risk Assessment Information for Enrolled Members at:
healthpartners.com/stateofwis

Humana – Eastern

(800) 4humana ((800) 448-6262) or Enrollment Hotline (888) 393-6765
humana.com



What's New for 2013

Humana offers HumanaVitality, a health and wellness program that rewards healthy lifestyle choices for members and their families. Visit humana.com/Vitality for more information. Humana's robust online tools help you choose a provider, see claim status and more. For more information go to humana.com/custom_clients/stateofwi.

Provider Directory

Go to apps.humana.com/egroups/Wisconsin/home.asp. Or go to humana.com to search for a provider. Select **Find a Doctor**, enter your member ID or select **Employer Group Plan** (if on Medicare, select **Medicare**). Enter your zip code. Select **HMO Premier** (if on Medicare, select **Medicare PPO**). **HMO Premier** (or **Medicare PPO**) will not appear in the list if no providers are found in the area. Call (800) 4humana to request an HMO directory. HMO Premier is a national network, but you **must** select a Wisconsin-based primary care physician, regardless of your address. Providers outside of Wisconsin may require a referral in addition to those required by Humana. Referrals are not required in the Medicare PPO plan.

Humana is Unique for Members on Medicare

If you are retired and enrolled in Medicare Parts A and B, Humana will automatically enroll you in a Humana Medicare Advantage PPO plan. You will still have the Uniform Benefits coverage, plus more. You have flexibility to see virtually any provider in the country, but will pay 10% coinsurance, up to an annual \$500 out-of-pocket limit when seeing providers out of the network. For enrollment questions or an enrollment kit with area PPO directory, call Humana Group Medicare Enrollment at (866) 396-8810.

Referrals and Prior Authorizations

Referrals are required to see some network providers and all providers outside the HMO Premier network. Prior authorizations are required for certain services. Your primary care physician must call (800) 523-0023 to make the request. Verify the status of the request by logging on to your MyHumana web page or calling (800) 4humana.

Care Outside Service Area

Call Humana at (800) 523-0023 within 48 hours after receiving emergency or urgent care outside our network.

Mental and Behavioral Health Services

Before seeking any mental or behavioral health services, call (800) 4humana between 8:00 a.m. and 5:30 p.m., and follow the prompts. A behavioral health specialist will assist you.

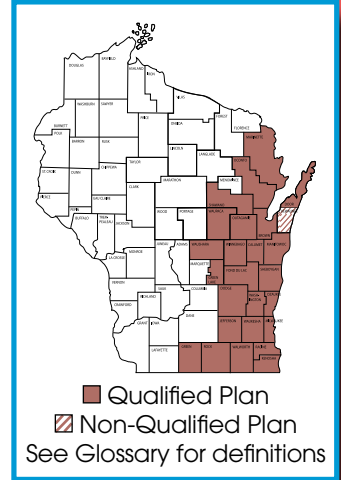
Dental Benefits (Contact plan for full details.)
Preventive Services: 100% - Exams, cleanings, fluoride, X-rays.

Restorative Services: 50% after deductible (\$25 per individual/\$75 per family) - Emergency care, surgery, amalgam.

Annual Benefit Maximum: None.

Orthodontics: 50% - dependents younger than age 18. Lifetime maximum \$1,200.

Dental Network: Go to humanadental.com. Follow the Provider Directory Instructions and select **Dentists** as the type of provider.



Health Risk Assessment Information for Enrolled Members at:
myhumana.com

Humana – Western

(800) 4humana ((800) 448-6262) or Enrollment Hotline (888) 393-6765
humana.com



Overall Quality Rating

See Report Card section

What's New for 2013

Humana offers HumanaVitality, a health and wellness program that rewards healthy lifestyle choices for members and their families. Visit humana.com/Vitality for more information. Humana's robust online tools help you choose a provider, see claim status and more. For more information go to humana.com/custom_clients/stateofwi.

Provider Directory

Go to apps.humana.com/egroups/Wisconsin/home.asp. Or go to humana.com to search for a provider. Select **Find a Doctor**, enter your member ID or select **Employer Group Plan** (if on Medicare, select **Medicare**). Enter your zip code. Select **HMO Premier** (if on Medicare, select **Medicare PPO**). **HMO Premier** (or **Medicare PPO**) will not appear in the list if no providers are found in the area. Call (800) 4humana to request an HMO directory. HMO Premier is a national network, but you **must** select a Wisconsin-based primary care physician, regardless of your address. Providers outside of Wisconsin may require a referral in addition to those required by Humana. Referrals are not required in the Medicare PPO plan.

Humana is Unique for Members on Medicare

If you are retired and enrolled in Medicare Parts A and B, Humana will automatically enroll you in a Humana Medicare Advantage PPO plan. You will still have the Uniform Benefits coverage, plus more. You have flexibility to see virtually any provider in the country, but will pay 10% coinsurance, up to an annual \$500 out-of-pocket limit when seeing providers out of the network. For enrollment questions or to request an enrollment kit with area PPO directory, call Humana Group Medicare Enrollment at (866) 396-8810.

Referrals and Prior Authorizations

Referrals are required to see some network providers and all providers outside the HMO Premier network. Prior authorizations are required for certain services. Your primary care physician must call (800) 523-0023 to make the request. Verify the status of the request by logging on to your MyHumana web page or calling (800) 4humana.

Care Outside Service Area

Call Humana at (800) 523-0023 within 48 hours after receiving emergency or urgent care outside our network.

Mental and Behavioral Health Services

Before seeking any mental or behavioral health services, call (800) 4humana between 8:00 a.m. and 5:30 p.m., and follow the prompts. A behavioral health specialist will assist you.

Dental Benefits (*Contact plan for full details.*)

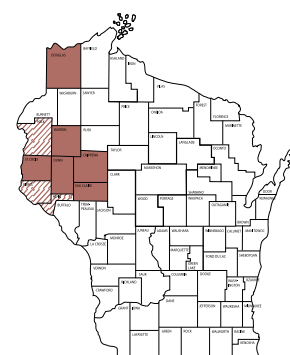
Preventive Services: 100% - Exams, cleanings, fluoride, X-rays.

Restorative Services: 50% after deductible (\$25 per individual/\$75 per family) - Emergency care, surgery, amalgam.

Annual Benefit Maximum: None.

Orthodontics: 50% - dependents younger than age 18. Lifetime maximum \$1,200.

Dental Network: Go to humanadental.com. Follow the Provider Directory instructions and select **Dentists** as the type of provider.



■ Qualified Plan
▨ Non-Qualified Plan
See Glossary for definitions

Health Risk Assessment Information for Enrolled Members at:
myhumana.com

Medical Associates Health Plans

(800) 747-8900

mahealthcare.com

★★★★☆
Overall Quality Rating
See Report Card section

What's New for 2013

Medical Associates Health Plans promotes health and wellness. To encourage individuals to take an active role in their health, MAHP is offering each enrolled adult who completes a health risk assessment in 2013 a \$50 gift card. Visit our website for additional details. There are no significant changes to the MAHP network. Check out the **mahealthcare.com** website to find plan information and health-related topics or log in to **myELINK** for personalized claims information, explanations of benefits and plan information.

Provider Directory

Go to **mahealthcare.com/OnlineDirectories/EmpGroup.aspx** or visit the MAHP's website at **mahealthcare.com** to view an online provider directory. You may also call MAHP at (800) 747-8900 to request a directory.

Referrals and Prior Authorizations

Members do not need to obtain referrals to receive care within the MAHP network. However, members must obtain written authorization from the MAHP medical director prior to receiving services from a provider outside of the MAHP network. If services cannot be provided by a physician within the MAHP network, your physician will initiate the request for prior authorization. MAHP will review the request and respond in writing to you and your physician. Call MAHP to confirm the status of your authorization request before receiving services.

Care Outside Service Area

If you need urgent or emergency care when you are outside of the MAHP service area, contact MAHP Health Care Services at (800) 325-7442 (number shown on the back

of your MAHP ID card) prior to receiving care or as soon as reasonably possible. Present your MAHP ID card to the facility for proper billing. All other care should be obtained from an MAHP participating physician or provider unless it is prior authorized as explained above.

Mental and Behavioral Health Services

Services must be obtained from a physician or provider in the MAHP network. No referral or prior authorization is needed.

Dental Benefits (*Contact plan for full details.*)

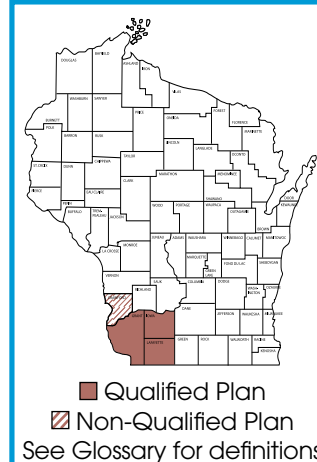
Preventive Services: *Covered at 100%:* Exams and cleanings, two per calendar year; fluoride (under age 19), two per calendar year; sealants (under age 14); bite-wing X-ray, one per calendar year; one full-mouth X-ray in a three-calendar-year period.

Restorative Services: *Covered at 80%, up to the annual maximum benefit:* Amalgams (silver) and restorative compositions (tooth colored for front teeth only).

Annual Maximum Benefit: \$1,000 per member.

Orthodontics: 50% coverage, up to a \$1,500 lifetime maximum (must start services by age 19).

Dental Network: You may see the dentist of your choice. Benefits are not subject to usual and customary charges.



Health Risk Assessment Information for Enrolled Members at:

Contact PathwaysHealthCoach@mahealthcare.com to establish a user name and password, then go to mahealthcare.com/Health_Wellness/Personal_Wellness.cfm

Medicare Plus

Administered by WPS Health Insurance
(800) 634-6448 wpsic.com/state

Not Available
Overall Quality Rating
See Report Card section

What's New for 2013

In the past, members have asked for a true Medicare Supplement plan. Medicare Plus will be that plan for eligible annuitants and their dependents who select the Standard Plan. Medicare Plus will pay your Medicare Part A and B deductibles and coinsurance. This group plan is superior to individual Medicare supplements as it provides protections from fees that exceed usual, customary and reasonable amounts if members use a provider who is not affiliated with Medicare. It also offers coverage during foreign travel. Note, however, in other cases if Medicare excludes coverage for a service, this plan will also deny coverage.

Last year WPS offered a basic health risk assessment (HRA) as an option to allow members to better understand the health risks associated with responses given to the health and wellness questions. As a way to continue assisting our members with your health and wellness goals, this year WPS will offer a more complete HRA that will include biometric screening. Biometric screening determines the risk level of an individual for certain diseases and other medical conditions. By knowing risk levels, an individual can better make decisions related to their health and wellness. To request an HRA, see the contact information below.

General Information

The Medicare Plus plan is designed to supplement, not duplicate, the benefits available under Medicare for State of Wisconsin Group Health Insurance Program annuitants.

See the Comparison of Benefit Options section for **benefit differences starting on Page 27**, and view the Health Care Benefit Plan booklet at etf.wi.gov/publications/et4113.pdf.

Provider Directory

None. This plan provides you with freedom of choice among hospitals and physicians in Wisconsin, nationwide and for travel abroad.

Referrals and Prior Authorizations

Referrals and prior authorizations are not necessary under this plan as benefits are only supplemental to approved Medicare benefits.

Mental and Behavioral Health Services

Medically necessary services are available when performed by licensed mental health professionals practicing within the scope of their license. Inpatient services will be limited to 120 days.

Dental Benefits

No dental coverage provided.

Health Risk Assessment Information for Enrolled Members:
Contact Mark Mitchell at (888) 333-5003

MercyCare Health Plans

(800) 895-2421

mercycarehealthplans.com



Overall Quality Rating

See Report Card section

What's New for 2013

MercyCare's network has expanded to include a new emergency care facility at Mercy Clinic North in Janesville. Holding your place in line at a Mercy emergency room or urgent care is easy. Choose the facility you want, select a projected treatment time, fill out a form, then relax from the comfort of your home until it's time to go. This is a FREE service provided by Mercy Health System. Visit the mercyinquicker.org website.

Provider Directory

Go to mercycarehealthplans.com, click on **State of Wisconsin Members**, click on **Provider Directory**.

Referrals and Prior Authorizations

You have open access to your primary care provider. A referral from your primary care provider is required to see a specialist in MercyCare's network. If the care is not available in MercyCare's network, your primary care physician must request a prior authorization from MercyCare. MercyCare will notify you in writing if authorization is approved or denied. Prior authorization is also required for specific services. If you have questions, contact customer service at (800) 895-2421.

Care Outside Service Area

If you require emergency care, you should seek care from the nearest physician, hospital or clinic. Contact customer service at (800) 895-2421 for all emergency or out-of-state inpatient admissions within 48 hours or as soon as reasonably possible.

Mental and Behavioral Health Services

Mental health and substance abuse services must be obtained from a provider in MercyCare's network. Outpatient visits do not require prior authorization. Inpatient and transitional care require prior authorization. Contact customer service at (800) 895-2421 with any questions.

Dental Benefits—Delta Dental of Wisconsin (Contact plan for full details.)

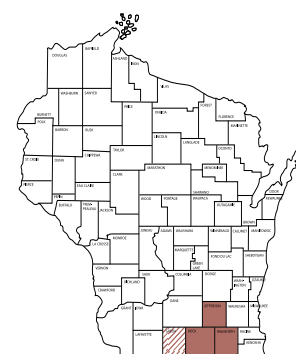
Preventive Services: Covered at 100%: exams, cleanings, fluoride treatments, X-rays, space maintainers and sealants, every six months.

Restorative Services: Covered at 80% after deductible (\$25 per individual; \$75 per family): fillings, emergency treatment, non-surgical and oral surgery. Covered at 50% after deductible: periodontics and endodontics.

Annual Benefit Maximum: \$1,000 per individual.

Orthodontics: 50% for dependents younger than age 19, up to an individual lifetime maximum of \$1,500.

Dental Network: Go to deltadentalwi.com. Under **Looking for a Dentist** click on **Dentist Search**. Select **Premier** or **PPO** as your dental plan. Call (800) 236-3713 with questions.



■ Qualified Plan
▨ Non-Qualified Plan
See Glossary for definitions

Health Risk Assessment Information for Enrolled Members at:
mercycarehealthplans.com, go to "Members," then "Health Risk Assessment"

Network Health Plan

(800) 826-0940

networkhealth.com



Overall Quality Rating

See Report Card section

What's New for 2013

Network Health Plan (NHP) will continue to offer Millennium Healthy Rewards, a great incentive for healthy living. By participating, you will receive a pedometer and also earn points for rewards. The Millennium website can be found at **networkhealth.com**. Go to **sign in for members**. Once logged in to **My Account**, click on **Millennium**.

Provider Directory

Go to **networkhealth.com**, under **Find a Doc/Location** choose **Group Health** for type of insurance, then select **State of Wisconsin Employee** as your network, or call (800) 826-0940 to request a copy.

Referrals and Prior Authorizations

You do not need a referral to see providers participating in NHP's network. However, prior authorization is required to see a provider that is not in NHP's network. Prior authorizations are also required for certain services. Members should contact NHP's customer service for information on specific health care services that require prior authorization. Your doctor must submit the prior authorization request, and NHP will notify you of the approval or denial.

Care Outside Service Area

Emergency and urgent care outside the service area is covered when medically necessary. Call us at (800) 236-0208 within 48 hours of going to an emergency room or a non-participating hospital. All other care, including follow-up care, must be obtained from participating providers, unless it is authorized by NHP as explained above.

Mental and Behavioral Health Services

Prior authorization is required for all behavioral health services. For assistance, please contact NHP's Care Management Behavioral Health Department at (800) 555-3616. After hours, call your provider or *NurseDirect* at (800) 362-9900.

Dental Benefits (Contact plan for full details.)

Preventive Services: Covered at 100%:

Exams, cleanings, fluoride treatments, X-rays, sealants and space maintainers.

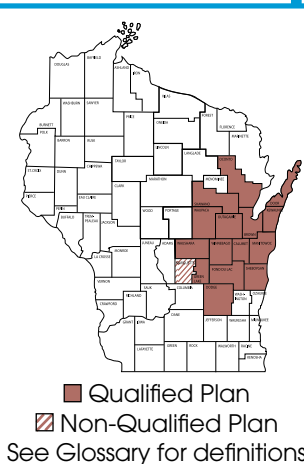
Restorative Services: Covered at 80%, subject to deductible: Emergency treatment to relieve pain, and fillings.

Annual Benefit Max: \$1,000/individual.

Deductible: \$25 individual/\$75 family.

Orthodontics: Covered at 50%, subject to deductible. Lifetime maximum is \$1,500. No adult orthodontics.

Dental Network: Go to **deltadentalwi.com** and choose **Delta Dental Premier** or **Delta Dental PPO** as your dental plan. You may also call Delta Dental at (800) 236-3712.



Health Risk Assessment Information for Enrolled Members at:
networkhealth.com, go to "My Account Sign In," and click on "WebMD"

Physicians Plus

(608) 282-8900 or (800) 545-5015

pplusic.com



Overall Quality Rating

See Report Card section

What's New for 2013

Using care navigation, our network of over 200 primary care physicians works closely with members to manage their overall health and access in-network specialty care. For out-of-network specialty services at centers of excellence, like UW Hospital, prior authorization will be required. Requests for local care will be honored before out-of-area options are considered. Primary care physicians at UW Health East, West, University Station and Oakwood clinics will no longer be available and specialty care will require prior authorization. New clinics, Meriter Fitchburg, Stoughton and Dermatology, are now open.

Provider Directory

Go to **pplusic.com** and click on **Find a Provider**. To print the provider listing, select **State of Wisconsin Employees/WPE Directory**. To search for a provider, select **State of Wisconsin/Wisconsin Public Employee (State/WPE)** under the network drop-down menu. Call (608) 282-8900 for a printed copy.

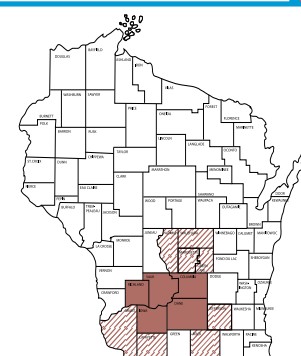
Referrals and Prior Authorizations

Prior authorization is not required for most covered services delivered by Physicians Plus network providers. Prior authorization will be required for out-of-network specialty services, including those at UW Hospital and our other centers of excellence like Children's Hospital of Wisconsin and Mayo Clinic. Members must have their provider submit a prior authorization request to Physicians Plus before receiving care from non-network providers. Written decisions will be provided to members and providers.

Care Outside Service Area

Emergency and urgent care outside the service area is covered when medically

necessary. Call Physicians Plus at (800) 545-5015 within 72 hours after receiving emergency or urgent care outside the Physicians Plus network. All other care, including follow-up care, should be obtained from network providers unless approved by Physicians Plus as described above.



■ Qualified Plan
▨ Non-Qualified Plan
See Glossary for definitions

Mental and Behavioral Health Services

Contact UW Behavioral Health at (608) 233-3575 or (800) 683-2300 for prior authorization Monday through Friday, 8:00 a.m. to 5:00 p.m. For emergencies, please contact your therapist. If you do not currently have a therapist, call a Physicians Plus participating emergency room. A mental health professional will assess your situation and refer you to the appropriate provider.

Dental Benefits (*Contact plan for full details.*)

Preventive Services: Covered at 100%. Exams, two cleanings per year, fluoride treatments, X-rays.

Restorative Services: Covered at 100%. Fillings, extractions. Other dental services covered up to \$75 member/calendar year.

Annual Benefit Maximum: Unlimited.

Orthodontics: Covered at 50%. Up to an individual maximum of \$1,500 for dependents younger than age 19.

Dental Network: Call (800) 545-5015 for participating providers. Dental services provided through Madison Family Dental Association (MFDA).

Members are now eligible for an additional \$50 in wellness incentives after completing their health assessment. Visit pplusic.com/members/member-materials/state for more information.

Security Health Plan

(800) 472-2363 or (715) 221-9555

securityhealth.org/state



Overall Quality Rating

See Report Card section

What's New for 2013

We want wellness to be a way of life, so this year we've added incentives to help you get there! Members who participate in our wellness programs can earn up to \$150 for a single or \$300 for a family. Complete your Health Risk Assessment and obtain your biometric numbers before April and you'll be entered in a drawing for one of 10 iPad3s we'll give away. Due to the overwhelming response we received from surveyed members, we've also added dental benefits that will make you smile. Find out more about these and other fabulous benefits at securityhealth.org/state.

Provider Directory

Visit securityhealth.org/state and click on **Provider Directory**. For a printed copy, contact customer service at (800) 472-2363.

Referrals and Prior Authorizations

Referrals: Required prior to seeing providers outside of the network.

Prior authorizations: Required for certain services. See our Member Handbook or call customer service for more information. You or your doctor must submit the request. Security Health Plan will notify you in writing of its decision.

Care Outside Service Area

For emergency and urgent care outside of the network, you must notify Security Health Plan by the next business day or as soon as possible to ensure appropriate claim payment.

All other care obtained through providers outside of the network will not be covered unless a referral has been approved by Security Health Plan, as explained above.

Mental and Behavioral Health Services

You may see any provider in the network for mental/behavioral health care. You do not need a referral or authorization.

Dental Benefits (Contact plan for full details.)

Preventive Services:

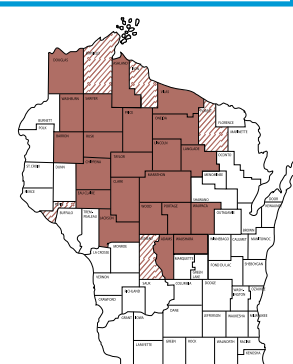
100% coverage after \$25 single/\$50 family deductible for office visits and oral examinations; cleanings (two per year); diagnostic and bite-wing X-rays (two per calendar year), fluoride application (one per calendar year for children under age 19).

Restorative Services: Plan will cover 50% of fillings, anesthesia, extraction of teeth, periodontics treatments, occlusal adjustments, and bruxism appliances up the plan maximum.

Annual Benefit Maximum: \$1,500.

Orthodontics: 50% for dependents younger than age 19, subject to a lifetime maximum benefit of \$1,500.

Dental Network: Receive your dental care from any dentist in the United States.



■ Qualified Plan
▨ Non-Qualified Plan
See Glossary for definitions

Health Risk Assessment Information for Enrolled Members at:
securityhealth.org/lifefocus

Standard Plan

Administered by WPS Health Insurance
(800) 634-6448 wpsic.com/state

Not Available
Overall Quality Rating
See Report Card section

What's New for 2013

Last year WPS offered a basic health risk assessment (HRA) as an option to allow members to better understand the health risks associated with responses given to the health and wellness questions. To continue assisting our members with your health and wellness goals, WPS will offer a more complete HRA that will include biometric screenings, which determine the risk level of an individual for certain diseases and other medical conditions. By knowing risk levels an individual can better make decisions related to their health and wellness. To request an HRA, see the contact information below.

General Information

The Standard Plan is a comprehensive health plan that provides you with freedom of choice among hospitals and physicians in Wisconsin and nationwide. A higher level of benefits is available by using preferred or in-network providers, which are available nationwide. See the Comparison of Benefit Options section for **benefit differences starting on Page 27** and view the Health Care Benefit Plan booklet for more complete details at eff.wi.gov/publications/et2112.pdf.

Provider Directory

Go to wpsic.com/state/pdf/dir2013_statewide_eastern.pdf or wpsic.com/state/pdf/dir2013_statewide_western.pdf to search for a provider within Wisconsin and bordering areas. You can also visit wpsic.com/state/fad2013_state_national.shtml to search for providers within Wisconsin, as well as nationwide. You may also contact member services to request a copy.

Pre-Certification

To avoid a \$100 inpatient benefit reduction, you, a family member or a provider must notify WPS of any inpatient hospitalization to request pre-certification.

Referrals and Prior Authorizations

- Referrals are not needed.
- Members or providers may request prior authorization for services when concerned if WPS will pay and at what rate. Without an approved prior authorization, WPS may deny payment. **Prior authorization is newly required for lower back surgery and high-tech radiology services.** Please visit wpsic.com/state and follow the **Member Materials** link to obtain a copy of a Medical Preauthorization Request Form or contact member services.

Mental and Behavioral Health Services

Medically necessary services are available when performed by licensed mental health professionals practicing within the scope of their license. Inpatient services will be limited to 365 days.

Dental Benefits

No dental coverage provided.

Health Risk Assessment Information for Enrolled Members:
Contact Mark Mitchell at (800) 333-5003

Standard Plan

Administered by WPS Health Insurance
(800) 634-6448 wpsic.com/state

Not Available
Overall Quality Rating
See *Report Card* section

What's New for 2013

Last year WPS offered a basic health risk assessment (HRA) as an option to allow members to better understand the health risks associated with responses given to the health and wellness questions. To continue assisting our members with your health and wellness goals, WPS will offer a more complete HRA that will include biometric screenings, which determine the risk level of an individual for certain diseases and other medical conditions. By knowing risk levels an individual can better make decisions related to their health and wellness. To request an HRA, see the contact information below.

General Information

The Standard Plan is a comprehensive health plan that provides you with freedom of choice among hospitals and physicians in Wisconsin and nationwide. A higher level of benefits is available by using preferred or in-network providers, which are available nationwide. See the Comparison of Benefit Options section for **benefit differences starting on Page 27** and view the Health Care Benefit Plan booklet for more complete details at eff.wi.gov/publications/et2112.pdf.

Provider Directory

Go to wpsic.com/state/pdf/dir2013_statewide_eastern.pdf or wpsic.com/state/pdf/dir2013_statewide_western.pdf to search for a provider within Wisconsin and bordering areas. You can also visit wpsic.com/state/fad2013-state-national.shtml to search for providers within Wisconsin, as well as nationwide. You may also contact member services to request a copy.

Pre-Certification

To avoid a \$100 inpatient benefit reduction, you, a family member or a provider must notify WPS of any inpatient hospitalization to request pre-certification.

Referrals and Prior Authorizations

- Referrals are not needed.
- Members or providers may request prior authorization for services when concerned if WPS will pay and at what rate. Without an approved prior authorization, WPS may deny payment. **Prior authorization is newly required for lower back surgery and high-tech radiology services.** Please visit wpsic.com/state and follow the **Member Materials** link to obtain a copy of a Medical Preauthorization Request Form or contact member services.

Mental and Behavioral Health Services

Medically necessary services are available when performed by licensed mental health professionals practicing within the scope of their license. Inpatient services will be limited to 365 days.

Dental Benefits

No dental coverage provided.

Health Risk Assessment Information for Enrolled Members:
Contact Mark Mitchell at (800) 333-5003

SMP – State Maintenance Plan

Administered by WPS Health Insurance
(800) 634.6448 wpsic.com/state

Not Available
Overall Quality Rating

See Report Card section

What's New for 2013

Last year WPS offered a basic health risk assessment (HRA) as an option to allow members to better understand the health risks associated with responses given to the health and wellness questions. To continue assisting our members with your health and wellness goals, WPS will offer a more complete HRA that will include biometric screenings, which determine the risk level of an individual for certain diseases and other medical conditions. By knowing risk levels an individual can better make decisions related to their health and wellness. To request an HRA, see the contact information below.

Provider Directory

Please visit wpsic.com/state/pdf/dir2013_state_smp.pdf to search for a provider or contact WPS member services.

Referrals and Prior Authorizations

You must get a referral approved by WPS before getting care outside the WPS SMP network. **Your provider must request the referral.** Retroactive referrals **are not** allowed. It is ultimately the member's responsibility to make sure the referral is submitted and approved prior to receiving services.

Members or providers may request prior authorization for services when concerned if WPS will pay and at what rate. Without an approved prior authorization, WPS may deny payment. **Prior authorization is newly required for lower back surgery and high-tech radiology services.** Please visit wpsic.com/state and follow the **Member Materials** link to obtain a copy of a Medical Preauthorization Request Form or call member services.

Care Outside Service Area

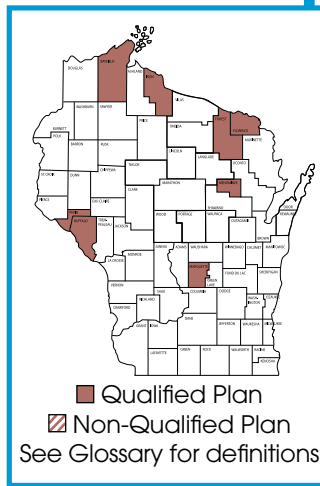
Emergency or Urgent Care: In-network hospital emergency rooms or urgent care facilities should be used whenever possible. Should you be unable to reach an in-network provider and cannot safely postpone the care, go to the nearest appropriate medical facility. Afterwards, contact member services by the next business day, or as soon as reasonably possible, and report where you received the care. Out-of-network care may be subject to Usual and Customary Charges. Non-urgent follow-up care must be received from an in-network provider.

Mental and Behavioral Health Services

Medically necessary services are available when performed by in-network licensed mental health professionals practicing within the scope of their license. Inpatient services will be limited to 365 days.

Dental Benefits

No routine dental coverage provided.



Health Risk Assessment Information for Enrolled Members:
Contact Mark Mitchell at (800) 333-5003

UnitedHealthcare of Wisconsin Northeast

(800) 357-0974 or (866) 873-3903 during the Enrollment Period
myuhc.com



Overall Quality Rating

See Report Card section

What's New for 2013

Each member who completes the online health risk assessment with biometric screening will receive a \$75 gift card. Innovative resources such as: the health care cost estimator tool, myHCE, to assist in decisions with more than 120 care paths; a new Health & Wellness tab personalized for individual goals and support; also check out our new Health4me App for access on the go!

Provider Directory

Go to **welcometouhc.com/state**, Find a **doctor/hospital**. Call customer service at (800) 357-0974 (current member) or (866) 873-3903 for a paper copy.

Referrals and Prior Authorizations

You do not need a referral to see a physician/hospital in the network. If a specific covered health service is not available from a network physician/hospital, your network physician must notify UnitedHealthcare (UHC) Care Coordination to request a "Network Gap Exception." In addition, you are responsible for notifying UHC's Care Coordination **before** obtaining services for dental/oral surgery or within 24 hours (or as soon as possible) of an emergency admission to a non-network hospital. You and your physician will be notified in writing of UHC's decision and coverage determination.

Care Outside Service Area

For emergency or urgent care, contact UHC's customer service at (800) 357-0974 as soon as possible. Care other than emergency or urgent care is not covered outside of the service area. Follow-up care will need to be completed in the service

area with your participating provider (see map at right).

Mental and Behavioral Health Services

Members must call United Behavioral Health (UBH) at (800) 851-5188 for an initial assessment and for authorization for any and all services with network providers. *Please note: After standard business hours, UBH can only manage inpatient benefits and authorizations.*

Dental Benefits (Contact plan for full details.)

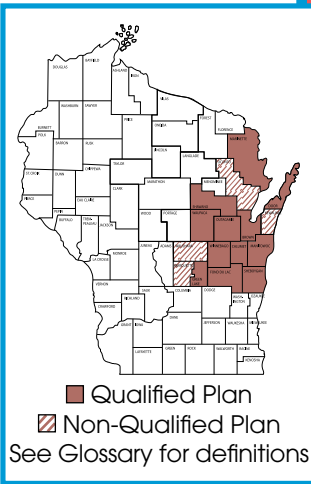
Preventive Services: Covered at 100%; Exams two times per calendar year, bite-wing X-rays, cleanings, fluoride treatments and sealants, complete series or panorex X-rays.

Restorative Services: Covered at 50% after deductible (\$50 individual/\$100 family): Amalgam and composite resin restorations, general anesthesia and space retainers. No coverage for major restorative services.

Annual Benefit Maximum: \$1,000 per person per calendar year.

Orthodontics: Covered at 50% for dependents younger than age 19, up to an individual orthodontic lifetime maximum of \$1,200.

Dental Network: Open dental network to go to a dentist of your choice. Charges are payable up to UHC's maximum allowable fee schedule.



Health Risk Assessment Information for Enrolled Members at:
myuhc.com, log on, then select "Health Risk Assessment" or call one of the numbers above

UnitedHealthcare of Wisconsin Southeast

(800) 357-0974 or (866) 873-3903 during the Enrollment Period
myuhc.com



Overall Quality Rating

See Report Card section

What's New for 2013

Each member who completes the online health risk assessment with biometric screening will receive a \$75 gift card. Innovative resources such as: the health care cost estimator tool, myHCE, to assist in decisions with more than 120 care paths; a new Health & Wellness tab personalized for individual goals and support; also check out our new Health4me App for access on the go!

Provider Directory

Go to **welcometouhc.com/state**, Find a **doctor/hospital**. Call customer service at (800) 357-0974 (current member) or (866) 873-3903 for a paper copy.

Referrals and Prior Authorizations

You do not need a referral to see a physician/hospital in the network. If a specific covered health service is not available from a network physician/hospital, your network physician must notify UnitedHealthcare (UHC) Care Coordination to request a "Network Gap Exception." In addition, you are responsible for notifying UHC's Care Coordination **before** obtaining services for dental/oral surgery or within 24 hours (or as soon as possible) of an emergency admission to a non-network hospital. You and your physician will be notified in writing of UHC's decision and coverage determination.

Care Outside Service Area

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area with your participating provider (see map at right).

Mental and Behavioral Health Services

Members must call United Behavioral Health (UBH) at (800) 851-5188 for an initial assessment and for authorization for any and all services with network providers. *Please note: After standard business hours, UBH can only manage inpatient benefits and authorizations.*

Dental Benefits (Contact plan for full details.)

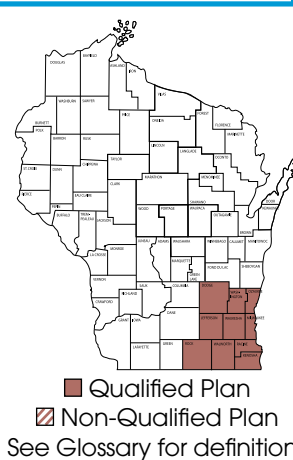
Preventive Services: Covered at 100%: Exams two times per calendar year, bite-wing X-rays, cleanings, fluoride treatments and sealants, complete series or panorex X-rays.

Restorative Services: Covered at 50% after deductible (\$50 individual/\$100 family): Amalgam and composite resin restorations, general anesthesia and space retainers. No coverage for major restorative services.

Annual Benefit Maximum: \$1,000 per person per calendar year.

Orthodontics: Covered at 50% for dependents younger than age 19 and up to an individual orthodontic lifetime maximum of \$1,200.

Dental Network: Open dental network to go to a dentist of your choice. Charges are payable up to UHC's maximum allowable fee schedule.



Health Risk Assessment Information for Enrolled Members at:
myuhc.com, log on, then select "Health Risk Assessment" or call one of the numbers above

Unity Health Insurance – Community

(800) 362-3310

chooseunityhealth.com



Overall Quality Rating

See Report Card section

What's New for 2013

Adult members will earn \$25 for taking an online health risk assessment (HRA). Go to **unitymychart.com**, log in, select **Wellness Programs** and then **Take an HRA**. Earn another \$25 when specific biometrics are submitted to Unity. To read more about this and quarterly wellness challenges visit **chooseunityhealth.com** and select **Health Risk Assessment and Wellness** under the **Unity Difference**. Want to learn more about how health insurance works? Check out Unity's new Resource Center at **chooseunityhealth.com/resourcecenter** where you will find educational videos, tools and other information to help you better understand health insurance. You continue to have guaranteed access to UW Health specialists.

Provider Directory

Go to **chooseunityhealth.com** and select **Find A Doctor**. Here you will find links to the 2013 Community Network Provider Directory (PDF) and the Community Network provider search function. You may also call (800) 548-6489 to request a copy of the Community Network Provider Directory.

Referrals and Prior Authorizations

Written referral requests are required to see providers not in the Community Network. Prior authorizations are required for certain services. See the Community Network Provider Directory for more information. Your doctor must submit the request. Unity will notify you in writing of our decision.

Care Outside Service Area

Call Unity at (800) 362-3310 within three business days after receiving emergency or urgent care services from an out-of-network

provider. All other care from out-of-network providers requires a written referral request as previously described.

Mental and Behavioral Health Services

Before getting services, you must call UW Behavioral Health at (800) 683-2300. Assistance is available 24 hours a day.

Dental Benefits

(Contact plan for full details.)

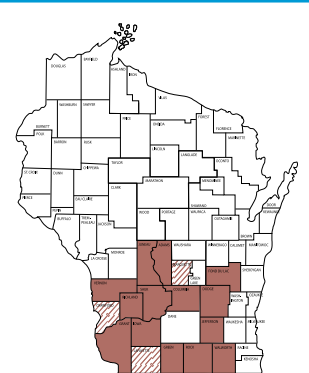
Preventive Services: *No deductible, covered at 100%:* exams, cleanings, bite-wing X-rays, and fluoride treatments (up to age 19) are covered two times per calendar year. Full mouth X-rays covered at three-year intervals. Palliative treatment of dental pain (minor procedure) is covered.

Restorative Services: *No deductible, covered at 100%:* amalgam fillings (composite in front teeth), one topical sealant application per tooth (to age 16) and non-surgical extractions.

Annual Benefit Maximum: \$1,000 per member.

Orthodontics: 50% for dependents under 19 years, up to a lifetime maximum of \$1,500.

Dental Network: Dental benefits are administered by Delta Dental. To find network dentists, go to **deltadentalwi.com** and select either **Delta Dental Premier** or **Delta Dental PPO** as your Dental Plan.



■ Qualified Plan
▨ Non-Qualified Plan
See Glossary for definitions

Health Risk Assessment Information for Enrolled Members at:
chooseunityhealth.com, sign-in for "My Chart," then select "Wellness Programs"
and "Health Risk Assessment"

Unity Health Insurance – UW Health

(800) 362-3310

chooseunityhealth.com



Overall Quality Rating

See Report Card section

What's New for 2013

Unity-UW Health has no in-network hospital or clinic changes in 2013. You continue to have guaranteed access to UW Health providers. Adult members will earn \$25 for taking an online health risk assessment (HRA). Go to **unitymychart.com**, log in, select **Wellness Programs** and then **Take an HRA**. Earn another \$25 when specific biometrics are submitted to Unity. Read more about this and quarterly wellness challenges at **chooseunityhealth.com** (select **Health Risk Assessment and Wellness** under the **Unity Difference**). Want to learn more about how health insurance works? Check out Unity's new online Resource Center at **chooseunityhealth.com/resourcecenter**.

Provider Directory

Go to **chooseunityhealth.com** and click **Find A Doctor**. Here you will find links to the 2013 UW Health Network Directory (PDF) and the UW Health Network provider search function. You may also call (800) 548-6489 to request a copy of the UW Health Network Provider Directory.

Referrals and Prior Authorizations

Written referral requests are *not* required to see providers in the UW Health Network. You will need a written referral request to see providers not in the UW Health Network. Prior authorizations are required for certain services. See the UW Health Network Provider Directory for more information. Your doctor must submit the request. Unity will notify you in writing of our decision.

Care Outside Service Area

Call Unity at (800) 362-3310 within three business days after receiving emergency or urgent care services from an out-of-network

provider. All other care from out-of-network providers requires a written referral request as previously described.

Mental and Behavioral Health Services

Before getting mental health services, you must call UW Behavioral Health at (800) 683-2300. For alcohol and other drug abuse (AODA) needs, call UW Health Gateway Recovery at (800) 785-1780. Assistance is available 24 hours a day.

Dental Benefits (*Contact plan for full details.*)

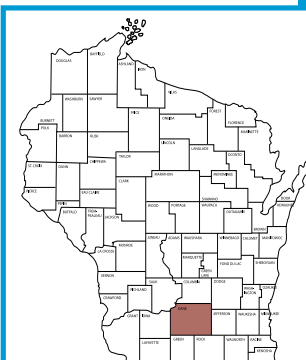
Preventive Services: *No deductible, covered at 100%:* exams, cleanings, bite-wing X-rays, and fluoride treatments (up to age 19) are covered two times per calendar year. Full mouth X-rays covered at three year intervals. Palliative treatment of dental pain (minor procedure) is covered.

Restorative Services: *No deductible, covered at 100%:* amalgam fillings (composite in front teeth), one topical sealant application per tooth (to age 16) and non-surgical extractions.

Annual Benefit Maximum: \$1,000 per member.

Orthodontics: 50% for dependents under 19 years, up to a lifetime maximum of \$1,500.

Dental Network: Dental benefits are administered by Momentum Insurance Plans Inc. To find network dentists, go to **momentumplans.com/unity**.



■ Qualified Plan
▨ Non-Qualified Plan
See Glossary for definitions

Health Risk Assessment Information for Enrolled Members at:
chooseunityhealth.com, sign-in for "My Chart," then select "Wellness Programs"
and "Health Risk Assessment"

WEA Trust PPO – East

(800) 279-4000 or (608) 276-4000

weatruststatehealthplan.com



Overall Quality Rating

See Report Card section

What's New for 2013

An easy way for all eligible family members to earn a \$150 prepaid cash card. You just need to complete our online health assessment and submit verifiable results for blood pressure, body mass index, and fasting cholesterol and glucose.

Also, six more counties—Adams, Juneau, Langlade, Lincoln, Menominee and Taylor—join the WEA Trust PPO East Network, which now totals 37 counties and covers most of eastern Wisconsin.

Provider Directory

Go to weatruststatehealthplan.com. From there, you may search for a doctor or print from a PDF. You may also call customer service at (800) 279-4000 for assistance.

How WEA Trust PPO East is Unique

WEA Trust PPO East is a preferred provider plan that allows you to see any provider and receive benefits—a broader alternative to HMOs that limit choices. Services received from non-network providers are covered too, but reimbursed at a lesser benefit level. (Also see Care Outside Service Area section.)

Referrals and Prior Authorizations

Referrals are not necessary. Some services require prior authorization—see a complete list at weatruststatehealthplan.com or call customer service at (800) 279-4000.

Care Outside Service Area

If you see a non-network provider, WEA Trust will pay for covered services at 70% of our maximum allowable fee, subject to an annual deductible of \$1,000 individual/\$2,000 family. For emergency and urgent care, use WEA Trust PPO East Network providers wherever possible.

Mental and Behavioral Health Services

WEA Trust covers mental and behavioral health in the same manner as other medical services. No referrals are needed.

Dental Benefits (*Contact plan for full details.*)

Preventive Services:

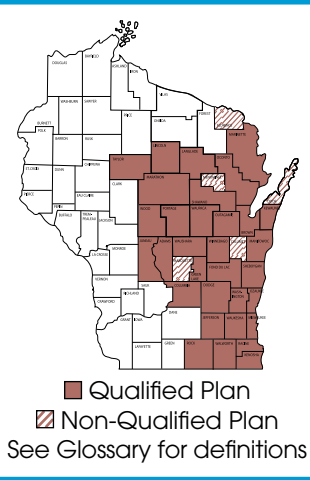
Covered at 100%: Exams, cleanings two times per year; bite-wing X-rays; fluoride treatments and sealants for dependent children.

Restorative Services: 80% coverage for fillings, extractions and periodontal services. 50% coverage for crowns and onlays, but does not include implant crowns.

Annual Benefit Maximum: \$1,000 per individual. No deductible.

Orthodontics: 50% coverage for dependents up to age 19, with an individual lifetime maximum of \$1,500.

Dental network: Click **Find a Dentist** at weatruststatehealthplan.com or call customer service at (800) 279-4000. You may see any dentist, but reimbursement for non-network providers is limited by WEA Trust's maximum reimbursement amount. Using non-network providers will likely increase your out-of-pocket costs.



Health Risk Assessment Information at:
weatrust.com/rewards

WEA Trust PPO – Northwest

(800) 279-4000 or (608) 276-4000

weatruststatehealthplan.com

Not Available
Overall Quality Rating

See Report Card section

What's New for 2013

An easy way for all eligible family members to earn a \$150 prepaid cash card. You just need to complete our online health assessment and submit verifiable results for blood pressure, body mass index, and fasting cholesterol and glucose.

Also, Clark County joins the WEA Trust PPO Northwest Network, which now totals 19 counties.

Provider Directory

Go to weatruststatehealthplan.com. From there, you may search for a doctor or print from a PDF. You may also call customer service at (800) 279-4000 for assistance.

How WEA Trust PPO Northwest is Unique

WEA Trust PPO Northwest is a preferred provider plan that allows you to see any provider and receive benefits—a broader alternative to HMOs that limit choices. Services received from non-network providers are covered too, but reimbursed at a lesser benefit level. (Also see Care Outside Service Area section.)

Referrals and Prior Authorizations

Referrals are not necessary. Some services require prior authorization—see a complete list at weatruststatehealthplan.com or call customer service at (800) 279-4000.

Care Outside Service Area

If you see a non-network provider, WEA Trust will reimburse for covered services at 70% of our maximum allowable fee, subject to an annual deductible of \$1,000 individual/\$2,000 family. For emergency and urgent care, use network providers wherever possible.

Mental and Behavioral Health Services

WEA Trust covers mental and behavioral health in the same manner as other medical services. No referrals are needed.

Dental Benefits (*Contact plan for full details.*)

Preventive Services:

Covered at 100%:

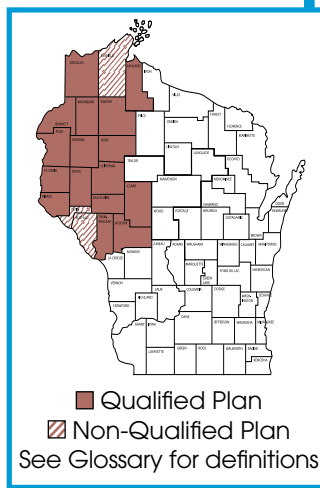
Exams, cleanings two times per year; bite-wing X-rays; fluoride treatments and sealants for dependent children.

Restorative Services: 80% coverage for fillings, extractions and periodontal services; 50% coverage for crowns and onlays, but does not include implant crowns.

Annual Benefit Maximum: \$1,000 per individual. No deductible.

Orthodontics: 50% coverage for dependents up to age 19, with an individual lifetime maximum of \$1,500.

Dental network: Click **Find a Dentist** at weatruststatehealthplan.com or call customer service at (800) 279-4000. You may see any dentist, but reimbursement for non-network providers is limited by WEA Trust's maximum reimbursement amount. Using non-network providers will likely increase your out-of-pocket costs.



Health Risk Assessment Information at:
weatrust.com/rewards

WPS Metro Choice Northwest

(800) 634-6448

wpsic.com/state

Not Available
Overall Quality Rating

See Report Card section

What's New for 2013

WPS Metro Choice Northwest is now available in: Barron, Burnett, Chippewa, Dunn, Eau Claire, Pierce, Polk, Rusk, Sawyer, St. Croix, and Washburn counties. We will also include a portion of SelectCare's network in Eastern Minnesota. WPS will offer a health risk assessment to include biometric screening, which determines the risk level of an individual for certain diseases and other medical conditions. By knowing risk levels, an individual can better make decisions related to health and wellness.

Provider Directory

Go to wpsic.com/state/pdf/dir2013_metro_choice_northwest.pdf to search for a provider or contact WPS member services at (800) 634-6448 to request a copy.

Referrals and Prior Authorizations

Referrals are not necessary under this plan. If you utilize providers outside the WPS Metro Choice network, you do not need a referral but the services are subject to a **deductible of \$1,000 individual/\$2,000 family and then payable at 70%**. Prior authorization is recommended for new medical or biomedical technology, methods of treatment by diet or exercise, new surgical methods or techniques, organ transplants, durable medical equipment over \$500 and pain management injections. Prior authorization is newly required for lower back surgery and high-tech radiology services. Members may also request prior authorization for any service to ensure coverage. WPS will notify you and your provider in writing of its decision.

Care Outside Service Area

In-network hospital emergency rooms or urgent care facilities should be used when possible. If you are unable to reach an in-network provider and cannot safely postpone the care until you return to the service area, go to the nearest appropriate medical facility and contact WPS as soon as possible.

Mental and Behavioral Health Services

Medically necessary services are available when performed by licensed mental health professionals practicing within the scope of their licenses.

Dental Benefits (*Contact plan for full details.*)

Preventive Services: 100% after deductible: exams, cleanings, fluoride treatments, and X-rays.

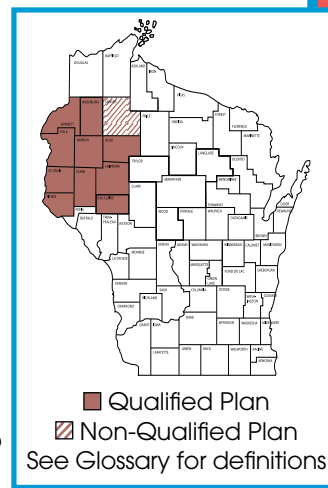
Restorative Services: 50% after deductible: sealants and fillings.

Annual Benefit Maximum: \$500 per individual.

Deductible: \$25 single/\$75 family per calendar year.

Orthodontics: Covered at 50% after deductible for dependents up to the age of 19 up to an individual lifetime orthodontic maximum of \$1,200.

Dental Network: Delta Dental Premier. Visit deltadentalwi.com to find a network dentist by clicking **Dentist Search** and then selecting **Delta Dental Premier** or by calling Delta Dental at (800) 236-3712.



Health Risk Assessment Information for Enrolled Members:
Contact Mark Mitchell at (800) 333-5003

WPS Metro Choice Southeast

(800) 634-6448

wpsic.com/state

Not Available
Overall Quality Rating

See Report Card section

What's New for 2013

WPS is pleased to announce an expansion. Metro Choice Southeast now includes Dodge and Jefferson counties. WPS will offer a health risk assessment to include biometric screening, which determines the risk level of an individual for certain diseases and other medical conditions. By knowing risk levels, an individual can better make decisions related to health and wellness.

Provider Directory

Go to wpsic.com/state/pdf/dir2013_metro_choice_southeast.pdf to search for a provider or contact WPS member services at (800) 634-6448 to request a copy.

Referrals and Prior Authorizations

Referrals are not necessary under this plan. If you utilize providers outside the WPS Metro Choice network, you do not need a referral but the services are subject to a **deductible of \$1,000 individual/\$2,000 family and then payable at 70%.**

Prior authorization is recommended for new medical or biomedical technology, methods of treatment by diet or exercise, new surgical methods or techniques, organ transplants, durable medical equipment over \$500 and pain management injections. Prior authorization is newly required for lower back surgery and high-tech radiology services. Members may also request prior authorization for any service to ensure coverage. WPS will notify you and your provider in writing of its decision on the authorization request.

Care Outside Service Area

In-network hospital emergency rooms or urgent care facilities should be used when

possible. If you are unable to reach an in-network provider and cannot safely postpone the care until you return to the service area, go to the nearest appropriate medical facility and contact WPS member services as soon as possible.

Mental and Behavioral Health Services

Medically necessary services are available when performed by licensed mental health professionals practicing within the scope of their licenses.

Dental Benefits (*Contact plan for full details.*)

Preventive Services: 100% after deductible: exams, cleanings, fluoride treatments, and X-rays.

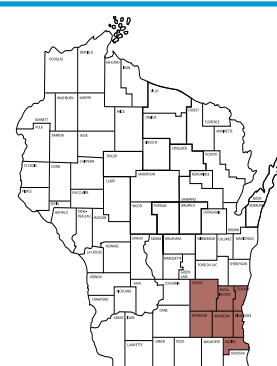
Restorative Services: 50% after deductible: sealants and fillings.

Annual Benefit Maximum: \$500 per individual.

Deductible: \$25 single/\$75 family per calendar year.

Orthodontics: Covered at 50% after deductible for dependents up to the age of 19 up to an individual lifetime orthodontic maximum of \$1,200.

Dental Network: Delta Dental Premier. Visit deltadentalwi.com to find a network dentist by clicking **Dentist Search** and then selecting **Delta Dental Premier** or by calling Delta Dental at (800) 236-3712.



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▨ Non-Qualified Plan
See Glossary for definitions

Health Risk Assessment Information for Enrolled Members:
Contact Mark Mitchell at (800) 333-5003

HEALTH PLAN REPORT CARD

This section provides the results of two important annual evaluations of our health plans—the member satisfaction survey—otherwise known as the Consumer Assessment of Healthcare Providers and Systems or CAHPS® — and quality performance measures — otherwise known as the Healthcare Effectiveness Data and Information Set or HEDIS® survey. We encourage you to review this information and evaluate how your current health plan compares with the other available health plans.

- The **Quality Composite** provides a summary of the health plans' quality scores in an overall composite. The Quality Composite Rating Chart includes all health plans that were available in 2012 and for which HEDIS® and CAHPS® data was available. Anthem Blue Northeast, Northwest and Southeast were combined into Anthem Blues for the purpose of calculating the composite scores.
- **CAHPS®** is our annual member survey. The survey reveals how members rate their health plan and the health care services they received. CAHPS® results were collected for active state, UW hospitals, clinics and university employees, including graduate assistants, and state retirees. The survey only includes health plans that were available starting on January 1,

2011, no data was collected for WEA Trust PPO Northwest or WPS Metro Choice Northwest. Although data was collected for the State Maintenance Plan (SMP), the results were not included in this report card due to the low number of respondents. ETF would like to thank all of the respondents for participating in this year's survey. We look forward to your continued support and cooperation in future member satisfaction surveys. This important survey was administered by Morpace, an independent research firm on the behalf of ETF.

- The **HEDIS®** survey shows the health plan's performance from a clinical perspective. The measures in this survey evaluate whether the health plan delivered the recommended care based on medical evidence to prevent or manage illness. HEDIS® measures address health care issues that are meaningful to members. HEDIS® data was collected by each health plan for its entire membership for the 2011 calendar year. No HEDIS® data is available for SMP, the Standard Plan or WPS Metro Choice.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

HEDIS® is a registered trademark of the National Committee for Quality Assurance.

PLEASE NOTE: ETF'S INTERNET SITE AT
eff.wi.gov CONTAINS MORE DETAILED INFORMATION.

QUALITY COMPOSITE RATING CHARTS

The following are descriptions of the rankings displayed in the chart on the next page.

Overall Quality Score

The overall score is based on a comprehensive set of CAHPS® and HEDIS® measures. All the measures that are included in the four areas of focus described below are included in the overall quality score.

Wellness and Prevention Score

This score includes HEDIS® measures such as childhood immunizations, well child visits, prenatal and postpartum care, the appropriate use of antibiotics for children and adults, and breast, cervical and colorectal cancer screenings. This composite also includes CAHPS® questions surveying our members about whether wellness information is provided by their doctor.

Behavioral and Mental Health

This score includes HEDIS® measures for the treatment of depression and follow-up after a hospitalization for mental illness. This composite also includes CAHPS® survey questions on whether members could obtain needed treatment or counseling for a personal or family problem.

Disease Management

This score includes HEDIS® measures that address treatment and screenings for members with acute cardiovascular conditions, hypertension, diabetes, chronic obstructive pulmonary disease and asthma. This composite also includes a measure that addresses monitoring members who are on persistent medications of interest.

Consumer Satisfaction and Experiences

This composite includes CAHPS® scores that measure member satisfaction with their health plan and the health care they received and whether they believed their health plan improved from the previous year. The composite also includes questions about member experiences such as getting needed care, getting care quickly, health plan customer service, finding and understanding information, ease of paperwork, and how claims were processed.

Example of information types gathered:

CAHPS®: How often did you get care as soon as you thought you needed it?

HEDIS®: What percentage of women age 42 to 69 had a mammogram within the last two years?

Quality Composite Rating Chart

Understanding the scores for the health plans:

- ★★★★★ 4 stars: **well above** the average of all health plans (by **more than** one standard deviation)*
- ★★★★ 3 stars: **above** the average of all health plans (by **less than** one standard deviation)*
- ★★★ 2 stars: **below** the average of all health plans (by **less than** one standard deviation)*
- ★ 1 star: **well below** the average of all health plans (by **more than** one standard deviation)*

Please see previous page for descriptions of the Quality Composite Ratings.

Plan Name	Overall Quality	Wellness & Prevention	Behavioral & Mental Health	Disease Management	Consumer Satisfaction & Experiences
Anthem Blues	★★	★	★★★★★	★★★★	★
Arise Health Plan	★★★	★★★	★★★	★★★★	★★★
Dean Health Plan	★★★	★★★	★★★	★★★★	★★★
GHC of Eau Claire	★★★	★★★	★★★	★★★★	★★★★
GHC of SCW	★★★★★	★★★★★	★★★★★	★★★★	★★★★
Gundersen Lutheran	★★★	★★★	★★★	★★★★	★★★
Health Tradition	★★★	★★★	★★	★★★★	★★
HealthPartners	★★★	★★★	★★★	★★★★	★★
Humana - Eastern	★	★	★	★	★
Humana - Western	★	★	★	★	★
Medical Associates	★★★	★★	★★	★★★★	★★★★
MercyCare Health Plans	★★★	★★★	★★★★★	★★★★	★★
Network Health Plan	★★★	★★★	★★	★★★★	★★★
Physicians Plus	★★★	★★★	★★★★★	★★★★	★★★
Security Health Plan	★★★	★★★	★★	★★★★	★★★★★
UnitedHealthcare NE	★	**NR	★★★	**NR	★★
UnitedHealthcare SE	★★	**NR	★★★	**NR	★★★
Unity - Community	★★★	★★★	★★★	★★★★	★★★
Unity - UW Health	★★★	★★★	★★★	★★★★	★★
WEA Trust PPO - East	★	**NR	★★★	**NR	★★★★★

*The standard deviation measures the difference between an individual health plan's score and the average score of all health plans. We are more certain that health plans with four stars have performed better than average and health plans with one star have performed worse than average. We cannot conclude that health plans with three stars or two stars have performed differently from the average.

**NR signifies that not all necessary data was reported.

CAHPS® Overall Rating Chart

Understanding the scores for the health plans:

- ★★★★ 4 stars: **well above** the average of all health plans (by **more than** 1.96 standard deviations)*
- ★★★ 3 stars: **above** the average of all health plans (by **less than** 1.96 standard deviations)*
- ★★ 2 stars: **below** the average of all health plans (by **less than** 1.96 standard deviations)*
- ★ 1 star: **well below** the average of all health plans (by **more than** 1.96 standard deviations)*

This chart shows results for individual survey questions for which members were asked to rate their health plan, health care, primary doctor and specialists. A 10 is the “best possible” rating, and 0 is the “worst possible” rating. Health plan scores were adjusted for age, education level, and self-reported health status.

↗ means that a health plan had a statistically significant improvement in their score from 2010 to 2011.

↘ means that a health plan had a statistically significant decline in their score from 2010 to 2011.

Plan Name	How people rated their HEALTH PLAN	How people rated their HEALTH CARE	How people rated their PRIMARY DOCTOR	How people rated their SPECIALIST
AVERAGE - All Health Plans	8.16	8.46	8.73	8.48
Anthem Blues	★	★★	★★★	★★★
Arise Health Plan	★★★★↘	★★★	★★	★★
Dean Health Plan	★★★★	★★★★	★★★	★★★
GHC of Eau Claire	★★★★↘	★★↘	★★	★★★
GHC of SCW	★★★★↘	★★★★↘	★★	★★★
Gundersen Lutheran	★★★★↘	★★★★↘	★★★	★★★
Health Tradition	★★★★↘	★★★	★★★★	★★★
HealthPartners	★★	★★	★★	★★
Humana - Eastern	★↘	★↘	★★★	★★★
Humana - Western	★	★★	★★	★★
Medical Associates	★★★★↘	★★★	★★★★	★★
MercyCare Health Plans	★★	★★	★★	★★★
Network Health Plan	★★★★↘	★★↘	★↘	★★
Physicians Plus	★★★★↘	★★★	★★↗	★★★
Security Health Plan	★★★★	★★★	★★★★↗	★★
Standard Plan	★★★	★★	★	★★
UnitedHealthcare NE	★★↘	★★★	★★	★★★
UnitedHealthcare SE	★★★	★★★★	★★★★	★★★
Unity - Community	★★★★	★★★	★★	★★★
Unity - UW Health	★★★★↘	★★★	★★	★★
WEA Trust PPO - East	★★★★	★★★★	★★★	★★★
WPS Metro Choice Southeast	★★	★★	★★★	★★

*The standard deviation measures the difference between an individual health plan's score and the average score of all health plans. We are more certain that health plans with four stars have performed better than average and health plans with one star have performed worse than average. We cannot conclude that health plans with three stars or two stars have performed differently from the average.

CAHPS® Composite Rating Chart

Understanding the scores for the health plans:

- ★★★★★ 4 stars: **well above** the average of all health plans (by **more than** 1.96 standard deviations)*
- ★★★★ 3 stars: **above** the average of all health plans (by **less than** 1.96 standard deviations)*
- ★★★ 2 stars: **below** the average of all health plans (by **less than** 1.96 standard deviations)*
- ★ 1 star: **well below** the average of all health plans (by **more than** 1.96 standard deviations)*

This chart shows results for a composite of survey questions that asked members how often something occurred ("Always," "Sometimes," "Usually" or "Never") regarding Customer Service, Claims Processing, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate and Shared Decision Making (between the member and the doctor). Health plan scores were adjusted for age, education level and self-reported health status.

↗ means that a health plan had a statistically significant improvement in their score from 2010 to 2011.

↘ means that a health plan had a statistically significant decline in their score from 2010 to 2011.

Plan Name	Customer Service	Claims Processing	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Shared Decision Making
AVERAGE - All Health Plans	3.45	3.45	3.37	3.51	3.70	3.51
Anthem Blues	★	★	★★★★	★★★★	★★★★	★★★★
Arise Health Plan	★★★★	★★★★★	★★★★★	★★★★★	★★★★	★★★★
Dean Health Plan	★★★★	★★★★	★★★★	★★★★	★★★★★	★★★★
GHC of Eau Claire	★★★★★	★★★★★	★★★★	★★	★★★★	★★★★
GHC of SCW	★★★★★	★★★★★	★★↘	★★	★★	★★★★
Gundersen Lutheran	★★★★	★★★★	★★★★	★★↘	★★★★	★★★★★
Health Tradition	★★↘	★★★★	★★	★★★★	★★★★★	★★★★
HealthPartners	★★★★	★★	★★	★★★★	★★	★★
Humana - Eastern	★	★↘	★★★★↘	★★	★★	★★
Humana - Western	★	★↗	★★↗	★★★★★	★★	★★
Medical Associates	★★	★★	★★★★↘	★★★★	★★★★	★★★★
MercyCare Health Plans	★★★★↗	★★	★★	★★	★★	★★★★
Network Health Plan	★★★★★↘	★★★★★	★★★★↘	★	★★	★★★★
Physicians Plus	★★★★	★★★★	★★	★	★★	★★
Security Health Plan	★★★★★	★★★★★	★★★★★	★★★★	★★★★	★★★★
Standard Plan	★★★★	★★★★	★★★★	★★	★	★
UnitedHealthcare NE	★	★★	★★★★★	★★★★	★★	★★★★★
UnitedHealthcare SE	★★	★★↘	★★★★★	★★★★	★★★★★	★★
Unity - Community	★★★★★	★★★★★	★★★★	★★★★	★★	★★★★
Unity - UW Health	★★★★	★★★★↘	★↘	★	★★★★	★★↘
WEA Trust PPO - East	★★★★★	★★★★★	★★★★★	★★★★★	★★★★	★★★★
WPS Metro Choice Southeast	★★★★	★★	★★★★	★★★★	★★	★★

*The standard deviation measures the difference between an individual health plan's score and the average score of all health plans. We are more certain that health plans with four stars have performed better than average and health plans with one star have performed worse than average. We cannot conclude that health plans with three stars or two stars have performed differently from the average.

HEDIS® Composite Chart

This chart displays the following quality measures:

- **Cancer Screenings**—This score includes the following HEDIS® measures: Colorectal, breast and cervical cancer screenings.
- **Appropriate Use of Antibiotics**—This score includes the following HEDIS® measures: Appropriate treatment for children with upper respiratory infection, appropriate testing for children with pharyngitis, avoidance of antibiotic treatment in adults with acute bronchitis.
- **Diabetes Care**—This score includes the following HEDIS® measures: HbA1c control, cholesterol screening and control, medical attention for kidney disease, eye exam, and blood pressure control.
- **Controlling High Blood Pressure**—This score examines the percentage of eligible members with high blood pressure who had their blood pressure controlled.
- **Cholesterol Management for Patients with Cardiovascular Conditions**—This score includes the following HEDIS® measures: Cholesterol screening and control.
- **Annual Monitoring for Patients with Persistent Medications**—This single score examines monitoring for the following drugs of interest: Angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB), digoxins, diuretics, anticonvulsants.

Plan Name	Cancer Screenings	Appropriate Use of Antibiotics	Diabetes Care	Controlling High Blood Pressure	Cholesterol Management for Patients with Cardiovascular Conditions	Annual Monitoring for Patients with Persistent Medications
Anthem Blues	★	★★	★★★★	★★★★	★★★★	★★★★
Arise Health Plan	★★	★★	★★★★	★★★★	★★★★	★
Dean Health Plan	★★	★★	★★★★	★★★★	★★★★	★★★★
GHC of Eau Claire	★★★★	★★★★	★★★★	★★★★	★★★★	★★
GHC of SCW	★★★★	★★★★★	★★★★	★★	★★★★	★★★★
Gundersen Lutheran	★★★★	★★★★	★★★★	★★★★	★★★★	★★
Health Tradition	★★	★★★★	★★★★	★★★★	★★★★	★★★★
HealthPartners	★★	★★★★	★★★★	★★★★	★★★★	★★★★
Humana	★★	★★	★★★★	★★	★★	★★★★
Medical Associates	★★	★★	★★★★	★★★★	★★★★	★★★★
MercyCare Health Plans	★	★★	★★★★	★★★★	★★★★	★
Network Health Plan	★★★★	★★	★★★★	★★	★★★★	★★
Physicians Plus	★★★★	★★★★	★★★★	★★★★	★★★★	★★★★
Security Health Plan	★★★★	★★	★★★★	★★★★	★★★★	★★★★★
UnitedHealthcare	★★★★	★★	*NR	*NR	*NR	★★
Unity Health Insurance	★★★★	★★	★★★★	★★	★★★★	★★★★
WEA Trust PPO - East	★★★★★	★★	*NR	*NR	*NR	★★★★

*NR signifies that not all necessary data was reported.

Please see Page 67 for a description of the star rating system that was used for this chart.

GRIEVANCE AND COMPLAINT INFORMATION



The health plan's grievance process is the required first step in resolving member complaints. Each health plan is required to have a grievance process in place for members to seek a change to an unfavorable decision. The most frequent types of grievances filed by members in 2011 were related to:

- Non-covered or excluded benefits;
- Health plan service and administration; and
- Prior authorizations.

An ETF complaint occurs when a member contacts ETF about an issue for input or investigation. The ombudsperson review is the initial, optional step involved in the administrative review process,

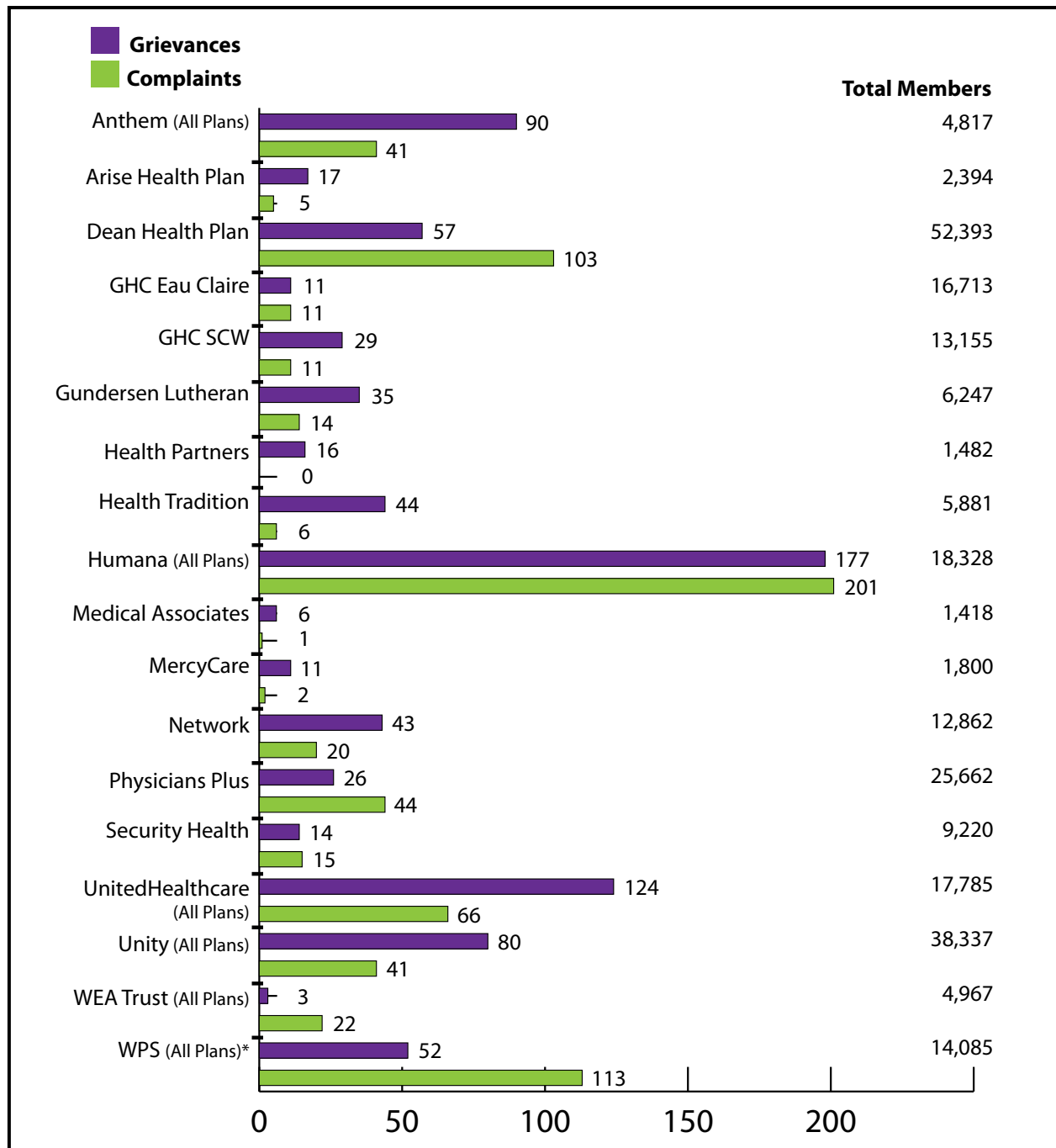
which allows members to appeal a plan decision to ETF and subsequently to the Group Insurance Board. The three most frequent issues about which members contacted ETF ombudspersons for assistance in 2011 were:

- Enrollment and eligibility;
- Billing and claim processing; and
- General program provision or design.

In 2011, 855 members filed grievances with their health plan and 997 members contacted ETF to request assistance or file a complaint. See the Grievances and Complaints by Health Plans chart on the following page.

Grievances and Complaints by Health Plan

This chart shows the total number of grievances and complaints for each health plan during the 2011 calendar year. The number on the right is the health plan's total number of members for 2011.



*Includes the Standard Plan, SMP and Medicare Plus.

OTHER QUALITY INFORMATION RESOURCES

There are several organizations that provide useful information about health care quality. We encourage you to look into the following resources.

Leapfrog

Leapfrog is a nationwide effort to address patient safety in hospitals, focusing on hospital quality and safety practices proven to reduce medical errors and save lives.

Through the Leapfrog website, consumers can select hospitals and compare their patient safety ratings performance.

leapfroggroup.org

CheckPoint

CheckPoint is a program sponsored by the Wisconsin Hospital Association. It provides a snapshot of hospital performance, and information may be used to compare how well hospitals administer recommended care. The 128 hospitals that currently participate in CheckPoint provide care to 99% of Wisconsin's patient population.

wicheckpoint.org

Wisconsin Collaborative for Healthcare Quality

The Wisconsin Collaborative for Healthcare Quality (WCHQ) provides links to a variety of performance measures that compare information from participating physician groups, hospitals and health plans. Consumers can view reports comparing the performance of providers on measures such as diabetes management, heart care, patient experience, pneumonia, cardiac surgery, surgery, women's health, chronic care, preventive care and more.

wchq.org

Hospital Compare

The Hospital Compare tool provides information about how well hospitals care for patients with specific medical conditions or surgical procedures and survey results from patients about the quality of care they received during a recent hospital stay. The site was created through the joint efforts of the Centers for Medicare and Medicaid Services, the U.S. Department of Health and Human Services, and other members of the Hospital Quality Alliance.

hospitalcompare.hhs.gov

Pharmacy — NAVITUS HEALTH SOLUTIONS™

Toll-Free Customer Care — (866) 333-2757
navitus.com



What's New for 2013

Level 4 Copayments for Specialty Medications

Effective January 1, 2013, a \$50, Level 4 copayment now applies to covered, formulary and non-formulary prescription drugs classified as specialty medications. A reduced, \$15 copayment applies when a covered, **formulary** specialty medication is filled at **Diplomat Specialty Pharmacy**. These formulary specialty medications are marked with "ESP" on the formulary. Please see additional information in the Specialty Medications Program section on the next page.

Out-of-Pocket Limits (OOPL)

Effective January 1, 2013, a separate Level 4 OOPL will apply to covered, formulary specialty medications: \$1,000 individual/\$2,000 family. This OOPL will accumulate separately from the Level 1/Level 2 OOPL for non-specialty, formulary

drugs, which is unchanged from 2012. Copayments for formulary specialty medications accumulate to the Level 4 OOPL; however, copayments for non-formulary drugs do not apply to any OOPL.

Medicare Prescription Drug Coverage

All Medicare-eligible retirees, as well as Medicare-eligible dependents of retirees, will be automatically enrolled in the Navitus MedicareRx (PDP), underwritten by Sterling Life Insurance Company. This is Medicare Part D coverage through an employer group waiver plan.

Formulary Information

The four-level formulary requires copayments of \$5 (Level 1), \$15 (Level 2), \$35 (Level 3) and \$50 (Level 4). Copayments for non-formulary drugs (all Level 3 and some Level 4 drugs) are not applied against the prescription drug or specialty medication OOPL. The most up-to-date formulary information is available on the Navitus website through Navi-Gate for Members. Under **Quick Links** click on **Members - Your Formulary** to log in, and then select the formulary named **State of WI and WI Public Employers (administered through ETF) Formulary**. You may also call Navitus Customer Care toll free at (866) 333-2757, with questions about the formulary.

Prior Authorization (PA) Requirements

A prior authorization is initiated by the prescribing physician on behalf of the member. Navitus will review the prior authorization request within two business days of receiving all necessary information from your physician. Medications that require prior authorization for coverage are marked with "PA" on the formulary.

Diabetic Supply Coverage

Diabetic supplies and glucometers are covered with a 20% coinsurance. In most cases this coinsurance applies to your

NAVITUS HEALTH SOLUTIONS™ — Pharmacy

(866) 333-2757 — Toll-Free Customer Care
navitus.com

prescription drug OOPL. Contact Navitus Customer Care if you have questions about your copayment applying to the OOPL.

90-Day-at-Retail Program

A 90-day supply of most maintenance medications can be purchased at your retail pharmacy. To take advantage of this program you must have three consecutive claims already processed for that drug in the Navitus claims system immediately before the 90-day supply is requested. In addition, your doctor must write the prescription specifically for a 90-day supply. Three copayments are still required. More information can be found on Navitus' website or by calling Navitus Customer Care.

Mail Order Program

Up to a 90-day supply of Level 1 and Level 2 medications can be purchased for only two copayments through our mail order service. Some Level 3 medication may also be available for up to a 90-day supply, but three copayments will apply. More detailed information can be found on the Navitus website; the WellDyneRx website (welldynernx.com) or by calling Navitus Customer Care. To register for mail order service, call WellDyneRx Customer Care toll free at (866) 490-3326, 24 hours a day, seven days a week.

RxCENTS Tablet-Splitting Program

By splitting a higher-strength tablet in half to provide the needed dose, you receive the same medication and dosage while buying fewer tablets and saving on copayments. Medications included in the program are marked with "¢" on the Navitus formulary. Members may obtain tablet splitting devices at no cost by calling Navitus Customer Care.

Generic Copay Waiver Program

Your first fill of a sample medication through this program is free. Medications included in this program are marked with "GW" on the Navitus formulary. To try this program, your doctor needs to write a prescription for one of the program medications. If it is your first time filling this prescription, you get the medication at no cost.

Specialty Medication Program (Self-Injectables and Specialty Medications)

If you are on a specialty medication, the Navitus SpecialtyRx Program is offered through a partnership with Diplomat Specialty Pharmacy to help coordinate members' specialty pharmacy needs. Prescriptions for formulary specialty medications, marked with "ESP" in the formulary, that are filled at Diplomat receive a reduced \$15 copayment. The reduced copayment does not apply to covered, non-formulary specialty medications. To begin receiving your self-injectable and other specialty medications from the specialty pharmacy, please call Navitus SpecialtyRx Customer Care at (877) 651-4943 or visit diplomatpharmacy.com.

Coordination of Benefits

Coordination of benefits applies when, as determined by the order of benefit determination rules, you have primary coverage under another policy and Navitus is your secondary coverage. All claims need to be submitted to your other policy first. Navitus covers the remaining cost of any covered prescriptions up to the allowed amount under your policies. Coordination of benefits does not guarantee that all of your out-of-pocket costs will be covered.

Pharmacy — NAVITUS MedicareRx (PDP)

Underwritten by Sterling Life Insurance Company

Toll-Free Customer Care — (866) 270-3877 medicarerx.navitus.com

Welcome!

Effective January 1, 2012, and each January 1st thereafter, all Medicare-eligible participants covered under an annuitant contract will be automatically enrolled in the Medicare Part D prescription drug program called Navitus MedicareRx (PDP), underwritten by Sterling Life Insurance Company, who is contracted with the federal government. Eligible individuals enrolled as members in the State of Wisconsin or Wisconsin Public Employers Group Health Insurance Program were covered by creditable coverage through Navitus Health Solutions prior to being enrolled in Navitus MedicareRx (PDP).

What does this mean to you?

You do not need to take any further action. You will maintain your current benefits. You will receive a new pharmacy benefit ID card that you will need to present to your pharmacy when you fill a prescription. The new ID card will be different than the regular Navitus ID cards issued to active employees and retirees not eligible for Medicare.

When you become eligible for coverage under Medicare Part D, you will be enrolled in the Navitus MedicareRx (PDP) through your employer group coverage. As required by Uniform Benefits, a “Wrap” benefit is also included to provide full coverage to program members when they reach the Medicare coverage gap, also known as the “donut hole.” You will be automatically enrolled in this “Wrap” coverage. Your formulary will include a four-level copayment structure which includes: \$5 (Level 1), \$15 (Level 2), \$35 (Level 3) and \$50/\$15 (Level 4). Information regarding your Medicare Part D benefit will be mailed to you by Navitus MedicareRx (PDP) upon confirmed enrollment from CMS.

Your welcome packet will include the following:

- **Your new ID card**
- **Summary of Benefits**
- **Pharmacy Directory**
- **Formulary**
- **Evidence of Coverage (details about your pharmacy coverage)**

PLEASE READ THIS NOTICE CAREFULLY AND KEEP IT WHERE YOU CAN FIND IT.

This notice has information about your prescription drug coverage with the program for people with Medicare.

By completing your enrollment application or maintaining your enrollment with the State of Wisconsin or Wisconsin Public Employers Group Health Insurance Program, you agree to the following:

I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform Navitus MedicareRx (PDP) of any prescription drug coverage that I have or may obtain in the future. I can only be in one Medicare prescription drug plan at a time—if I am currently in a Medicare prescription drug plan, my enrollment in Navitus MedicareRx (PDP) will end that enrollment. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes if an enrollment period is available, generally during the Annual Medicare Part D Enrollment Period (October 15 – December 7), unless I qualify for certain special circumstances.

Navitus MedicareRx (PDP) serves a specific service area. If I move out of the area that Navitus MedicareRx (PDP) serves, I need to notify the plan so I can disenroll and find a

NAVITUS MedicareRx (PDP)— Pharmacy

Underwritten by Sterling Life Insurance Company

Toll-Free Customer Care — (866) 270-3877 medicarerx.navitus.com

new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use Navitus MedicareRx (PDP) network pharmacies. Once I am a member of Navitus MedicareRx (PDP), I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Navitus MedicareRx (PDP) when I get it to know which rules I must follow to get coverage.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future. I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Navitus MedicareRx (PDP), he/she may be paid based on my enrollment in Navitus MedicareRx (PDP). Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or prescription drug plan options, medical assistance through the state Medicaid program, and the Medicare Savings Program.

Release of Information:

By joining this Medicare prescription drug plan, I acknowledge that Navitus MedicareRx (PDP) will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Navitus MedicareRx (PDP) will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes

which follow all applicable federal statutes and regulations. The information on my enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on my form, I will be disenrolled from the plan. I understand that my signature (or the signature of the person authorized to act on my behalf under state law where I live) on my application means that I have read and understand the contents of the application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete the enrollment; and 2) documentation of this authority is available upon request by Medicare or by my employer group.

This notice is provided each year, prior to the next Medicare prescription drug coverage enrollment period or whenever program coverage changes. For more information please contact either ETF or Navitus MedicareRx (PDP).

Navitus MedicareRx (PDP) Customer Care

CALL: (866) 270-3877—Calls to this number are free. Members can reach Navitus Customer Care 24 hours a day/seven days a week, except Thanksgiving and Christmas.

TTY: (866) 268-2501—This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. TTY hours are Monday through Friday 8:00 a.m. to 5:00 p.m. CST.

FAX: (920) 735-5309

WRITE: Navitus MedicareRx (PDP) Customer Care, P.O. Box 999, Appleton, WI 54912-0999

WEBSITE: medicarerx.navitus.com



STATE OF WISCONSIN
Department of Employee Trust Funds
Robert J. Conlin
SECRETARY

801 W Badger Road
PO Box 7931
Madison WI 53707-7931

1-877-533-5020 (toll free)
Fax (608) 267-4549
<http://etf.wi.gov>

Important Notice About Your Prescription Drug Coverage and Medicare

2013 Notice of Creditable Coverage for Medicare Part D

KEEP THIS NOTICE – DO NOT DISCARD

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the State of Wisconsin (State) or Wisconsin Public Employers (WPE) Group Health Insurance Program and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan under an individual policy. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering individual Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **The Department of Employee Trust Funds (ETF) has determined that the prescription drug coverage offered by the State and WPE programs, and administered by Navitus Health Solutions is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year after that from October 15 through December 7. If you lose your State or WPE prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

For Medicare eligible, active working individuals enrolled in the State or WPE group health insurance program, if you decide to join a Medicare drug plan, your current State or WPE prescription drug coverage will not be affected. You can remain enrolled in the State's or WPE's plan and prescription drug coverage through the State or WPE will be primary to Medicare Part D. However, there will be no reduction in your monthly premium. If you do decide to drop your current State or WPE coverage, be aware that you and your dependents may not be able to get this coverage back. The State and WPE benefit plan design doesn't allow you to drop prescription drug coverage and maintain health benefit coverage separately. Refer to the 2013 It's Your Choice Reference Guide (ET-2107r-13 for State or ET-2128r-13 for WPE) for more information on reenrolling in the State or WPE plan and the impact Medicare Part D has on your coverage.

For Medicare eligible, retired, disabled and COBRA individuals who are not actively working, prescription drug coverage is provided through a Medicare Part D employer group waiver plan, Navitus MedicareRx (PDP), underwritten by Sterling Life Insurance Company, which is considered creditable coverage.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

If you drop or lose your current coverage with the State or WPE program and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join another Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join a Medicare drug plan.

For More Information About this Notice or Your Current Prescription Drug Coverage...

Contact either Navitus or ETF.

Navitus Health Solutions

Phone toll free: 1-866-333-2757

Navitus MedicareRx (PDP)

Phone toll free: 1-866-270-3877

Hours: 24 hours a day, 7 days a week (Closed Thanksgiving and Christmas Day)

Department of Employee Trust Funds

Phone toll free..... 1-877-533-5020

Local to Madison..... (608) 266-3285

FAX..... (608) 267-4549

Website..... <http://etf.wi.gov>

Mailing Address:

P.O. Box 7931

Madison, WI 53707-7931

Wisconsin Relay Service (for hearing & speech impaired)

7-1-1 or 1-800-947-3529 (*English*) or 1-800-833-7813 (*Spanish*)

This notice is provided each year, prior to the next Medicare prescription drug coverage enrollment period or whenever State or WPE coverage changes. You may also request a copy of this notice from ETF at any time.

For More Information About this Notice or Your Current Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is available in the annual "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. While you may also be contacted directly by Medicare PDP providers, you can get more information about Medicare prescription drug coverage from the following sources:

- Visit www.medicare.gov;
- Call your State Health Insurance Assistance Program for personalized help (see the inside back cover of the "Medicare & You" handbook for their telephone number); or
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit the Social Security's website at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

REMEMBER: KEEP THIS CREDITABLE COVERAGE NOTICE.

If you decide to join one of the Medicare prescription drug plans approved by Medicare you may need to provide a copy of this notice when you join to show that you have maintained creditable coverage and, therefore, are not required to pay a higher premium (a penalty).

Life Insurance—Minnesota Life Insurance Company

(866) 295-8690

etf.wi.gov

Wisconsin Public Employees (WPE) Group Life Insurance

The life insurance program offers employees coverage of up to five times annual earnings.

- **Basic Plan** provides coverage equal to your previous year's earnings, rounded up to the next thousand. Basic coverage will continue in a reduced amount for life, without cost, for eligible retirees older than age 65 and for active employees older than age 70.
- **Supplemental Plan** provides coverage equal to your previous year's earnings, rounded up to the next thousand. Coverage may continue up to age 65, if retired, or age 70 for active employees.
- **Additional Plan** provides up to three units of coverage. Each unit of coverage equals your previous year's earnings, rounded up to the next thousand. Coverage may continue until you terminate employment, cancel coverage or stop paying premium.
- **Spouse and Dependent Plan** provides up to two units of coverage for your spouse or domestic partner and all dependent(s). Each unit of coverage provides \$10,000 in spouse coverage and \$5,000 coverage for each dependent.
- **Conversion of life insurance to pay health or long-term care premiums.**
Retirees who have WPE life insurance and have reached age 66 may be eligible to convert the present value of their life insurance to pay ETF-administered health or long-term care insurance premiums. See *Converting Your Group Life Insurance to Pay Health or Long-term Care Insurance Premiums* (ET-2325).
- **Living Benefits**—Insured persons may apply to receive all or part of the value of

their life insurance while still living, if they are diagnosed with a terminal condition caused by illness or injury and have a life expectancy of 12 months or less. See the *Living Benefits* (ET-2327) brochure.

- **Eligibility and Enrollment**—You have an open enrollment opportunity for life insurance coverage if you:
 - are younger than age 70;
 - have worked six or more months in service covered by the WRS; and
 - apply within 30 days of your first eligibility.

Note: Employees who reach 70 years old before becoming eligible for the coverage may be insured under the Additional Plan only. This is subject to evidence of insurability.

You may also enroll for one level of employee coverage or increase your coverage by one level if have a qualifying family status change event: marriage, domestic partnership as defined in Wis. Stat. 40.02(21d) or the birth, adoption, placement for adoption, or award of legal guardianship of a dependent child.

For Spouse and Dependent coverage only, you may apply when you first have a spouse, domestic partner or dependent to insure. If you do not enroll for all available coverage when you are first eligible, you may apply for future coverage only through *Evidence of Insurability* (ET-2305).

- See the *Wisconsin Public Employers Group Life Insurance Program* (ET-2101) brochure for complete program details.

Employee Reimbursement Accounts (ERA) Program

The Employee Reimbursement Accounts (ERA) program is an optional benefit that allows you to set aside pre-tax income to pay for eligible IRS-approved expenses. WageWorks administers the program.

Medical Expense Reimbursement Account

You may set aside as much as \$2,500 tax-free each year for health care expenses not covered by insurance, such as coinsurance, deductibles and copays; and non-covered items, such as eyeglasses and dental expenses. Keep in mind that Uniform Benefits now imposes a coinsurance of 90%/10% with an annual out-of-pocket limit of \$500 single/\$1,000 family on most illness or injury related services. (Preventive services are paid at 100%.) These expenses can be reimbursed through the Medical Expense Reimbursement Account.

Dependent Day Care Reimbursement Account

This account may be used for day care expenses for eligible dependent(s) that are incurred to allow you (and your spouse, if married) to work, look for work, or attend school full time. The maximum contribution amount allowed is \$5,000 per plan year per family, or \$2,500 per employee if married and filing taxes separately.

Plan carefully before you enroll.

In exchange for the tax advantages, the IRS has imposed strict rules. Funds remaining in your account(s) at the end of the plan year after all eligible expenses have been reimbursed will be forfeited. Also, once your coverage begins, the benefit election (including the insurance benefits for which premiums are being deducted on a pre-tax basis) cannot be cancelled or changed

during the plan year, unless you experience a valid Change In Status event as described in IRS regulations. If you have your health insurance deductions taken on a pre-tax basis, see the *Cancellation/Termination of Coverage* section of the *Frequently Asked Questions* in the *It's Your Choice: Reference Guide* for more information about mid-year coverage changes.

Before you enroll, check out the ERA enrollment booklet, available on the ETF website, for more detailed plan information. Review your health, vision and dental benefits for the 2013 plan year to determine the available benefits, copayments and/or deductibles. Also, review the Navitus formulary to determine your drug copayments. Keep in mind the out-of-pocket limits for drug coverage apply only to Level 1, Level 2 and Level 4 drugs in most cases. See the *Schedule of Benefits* in the *Uniform Benefits* section of the *It's Your Choice: Reference Guide* for more information.

Note: The IRS does not recognize domestic partner status. You cannot, therefore, be reimbursed for a domestic partner's or partner's child's medical or dependent day care expenses unless they meet the IRS definition of dependent.

Open Enrollment Period

ERA program 2013 plan year open enrollment is October 8 to November 2, 2012. Employees may enroll online at **wageworks.com**.

myETF BENEFITS SYSTEM INSTRUCTIONS AND INFORMATION

Employees* and annuitants are encouraged to submit their It's Your Choice Open Enrollment changes via the myETF Benefits Online Health Insurance Enrollment System. Enrolling in a health insurance plan is a quick and easy process through our dedicated and secure website.

*UW System employees: Do not use the myETF Benefits System to enroll in or make changes to coverage. Go to the UW System fall enrollment website at <http://uwservice.wisc.edu/2013>. Contact your UW institution's payroll and benefits office if you have questions about the enrollment process.

If you don't have access to a computer, you may submit your enrollment change on a paper application (enclosed). Employees should submit it to their benefits/payroll/personnel office. Annuitants/continuant should send the form to ETF. The address appears on the back cover of this Guide.

All changes must be entered online, submitted, faxed or postmarked no later than November 2, 2012.

Step 1

Home Page – Online Network for Members

Go to myETF.wi.gov/ONM.html (Online Network for Members). In order to login, you will need a Web Access Management System (WAMS) ID and your ETF Member ID (explained in Step 3). Click on the **myETF Benefits** link to begin the login steps.

Step 2

myIdentity Verification (WAMS ID)

Type your WAMS ID and password. Click **Login**.

If you don't have a WAMS ID, click **Register Now**. You will be taken through the quick and easy process to get one. Keep track of your WAMS ID and password, as you will need it in the future to view and change your coverage.

If you forgot your WAMS ID, click the appropriate **Go Here** link in the **Registered Users** section to recover your WAMS ID. If you need to change your WAMS ID e-mail address or password, click the appropriate **Go Here** link also in the **Registered Users** section.

myETF Benefits System Instructions

Step 3

myIdentity Verification (ETF Member ID)

Type your ETF Member ID (Employees: available on your Navitus Prescription Drug ID card, ETF Statement of Benefits or from your employer. Annuityants: available on your Annuity Payment Statement or from ETF) and birth date. Your birth date must be entered per the guidelines on the screen, for example, 02/01/1960. Click **Verify** to continue.

Step 4

myIdentity Verification (Social Security Number)

Type your Social Security number without the dashes. This is a one-time event that only needs to be completed the first time you log in.

After you are logged in, the myInfo page will appear, which displays your demographic information. On the top of the screen, there are other tabs that you can use to navigate. Click on the **Health** tab and the Health Insurance Enrollment Summary will appear with your current and historic health insurance information.

Step 5

myETF Benefits – It's Your Choice Change

To make your It's Your Choice Enrollment change, click the **Edit** button on the left toward the middle of the screen and complete the fields that appear. When complete, click the **Submit** button.

OR

Step 5

myETF Benefits - New Hire Enrollment

If you are a new employee enrolling for coverage for the first time, click the **Add Coverage** button at the bottom of the page to begin making your health insurance selections. When complete, click the **Submit** button.

Step 6

myETF Benefits - Log Off

Click the **Log Off** tab. You will receive an e-mail letting you know that your change is pending for review by your employer (ETF for annuityants). Later, you will receive a second e-mail informing you to check myETF Benefits to learn if your change was approved or denied.

Note: Employees with questions should contact their employers. Annuityants and continuants should contact ETF at 1-877-533-5020.



Group Health Insurance Applications



If you want to change health plans or change to family or single coverage, drop your adult dependent child or enroll if you previously deferred coverage (if you are an eligible employee, annuitant or surviving spouse/dependent) for next year, submit your completed application and retain one for your records. Copies of the *Group Health Insurance Application/Change Form* (ET-2301) are also available at **eff.wi.gov**.

Your application must be submitted electronically (see Pages 82 and 83), handed in, faxed or postmarked by the last day of the It's Your Choice Open Enrollment period (November 2, 2012). Late applications will not be accepted.

GROUP HEALTH INSURANCE APPLICATION/CHANGE FORM

State of Wisconsin Employees and Annuitants

Wisconsin Public Employees and Annuitants

UW Graduate Assistants, Employees in Training, Short-Term Academic Staff, Fellows and Scholars

Wis. Stat. § 40.51

You must submit this application to your employer if you are actively employed, or to the Department of Employee Trust Funds (ETF) if you are an annuitant or on continuation. Use this form to: decline, add or cancel health insurance coverage; change health plans, change coverage levels, or update personal information; and add or remove dependents. For complete enrollment and program information, read the *It's Your Choice* guides. Your initial enrollment period is as follows:

- a) Within 30 days of your date of hire to be effective the first of the month on or following receipt of application by the employer; or
- b) **State employees only**—Before becoming eligible for state contribution (completion of two months of state service under the Wisconsin Retirement System (WRS) for permanent/project employees; six months of state service for limited term employees or completion of 1,000 hours of service for WISCRAFT employees. This does not apply to UW unclassified faculty/academic staff.
- c) **Wisconsin Public Employers' participants only**—Within 30 days prior to becoming eligible for employer contribution.
- d) **Graduate Assistants only**—When you are notified of your appointment, immediately contact your benefits/payroll/personnel office for health insurance enrollment information and an application. If eligible, you may enroll for single or family coverage in any of the available health plans. Your benefits/payroll/personnel office must receive your application within 30 days of the date of your first eligible appointment. Your health insurance coverage will be effective the first day of the month on or following receipt of your application by your employer.

If this is not your first eligible appointment, you may still be eligible for the initial 30-day enrollment period if you had a 30-day employment break between appointments. If you are currently an active participant under the WRS, you are not eligible for coverage under the graduate assistant program.

If you choose to enroll within your initial enrollment period, we recommend that you submit this application to your employer immediately upon employment. If you missed your enrollment opportunity there may be other enrollment opportunities available. There are no interim effective dates, except as required by federal HIPAA law. If your application is submitted after these enrollment opportunities, you will not be eligible to enroll until the annual *It's Your Choice* Open Enrollment period. For complete enrollment and program information, read the *It's Your Choice* guides.



INSTRUCTIONS FOR COMPLETING HEALTH INSURANCE APPLICATION/CHANGE FORM

SECTION 1 – APPLICANT INFORMATION

1. Print your responses clearly and legibly; and provide all information requested.
2. Marital or Domestic Partnership Status: Check the box that applies to you. If you indicate that you are Married, Divorced, Widowed or in a Domestic Partnership, list the date in the space provided.
Note the effective date of a domestic partnership is the date that ETF receives the Affidavit of Domestic Partnership form (ET-2371). If married or in a domestic partnership, you must provide your spouse/domestic partner's name, prior name if any, SSN, birth date, even if you are applying for single coverage. If applying for family coverage, also include relationship, gender, tax dependent status, and physician.
3. For initial enrollment only, indicate when you want coverage to start: 1) immediately (as soon as possible); 2) when you become eligible for the employer contribution toward the health insurance premium; or 3) It's Your Choice Open Enrollment period.
4. Coverage Desired: Indicate level of coverage desired by checking either single or family.
5. Health Plan Selected: Indicate the name of the health plan that you want to provide your health insurance.

SECTION 2 – REASON FOR APPLICATION

1. Indicate the reason for submitting this application by checking the box(es) that apply under subsections A, B, C, D, E, F, G or H. If you are completing an application to change coverage level under subsection D, or to add a dependent under subsection H due to marriage, creating a domestic partnership, birth, adoption or placement for adoption, and also wish to change health plans under subsection C, a second application must be completed to change health plans.
2. Subsection A—If declining coverage, check a box and go to Section 7 to date and sign your application.
3. Subsection F—When updating personal data, this can be done on the same application when selecting a reason under subsections B, C, D, E, G or H, or on a separate application.
4. If electing a Change from Family to Single Coverage or Canceling Coverage, you must also check the pre-tax/post-tax box that applies. If you have your employee premium share taken pre-tax, Internal Revenue Code Section 125 restricts mid-year changes to your coverage. If electing single coverage due to your spouse and all dependents, or your last covered dependent, becoming eligible for and enrolling in other group coverage, an application must be received by your employer or a myETF Benefits request submitted within 30 days of their enrollment in the other group coverage.
5. Removing Adult Dependents - Dependents under the age of 19 cannot be dropped from coverage when family coverage is in place. Once the dependent turns age 19, that adult dependent can be dropped at the end of the calendar year they turned 19 during the It's Your Choice Open Enrollment period. An adult dependent can be dropped or added during any It's Your Choice period.

SECTION 3 – APPLICANT/DEPENDENT INFORMATION

Provide all information requested in this Section for any eligible dependents, if applicable, when selecting a reason under Adding Coverage, Subsection 2B; Changing Health Plan, Subsection 2C; and Changing Coverage Level, Subsection 2D.

When selecting a reason under Remove Dependents, Subsection 2G; or Add Dependents, Subsection 2H, provide all information requested in the Dependent Information Section for all dependents who are being removed or added. If adding or removing a spouse/domestic partner due to marriage or creation of domestic partnership, divorce/termination of domestic partnership or death, please provide all the information requested.

For "Rel. Code," use the following codes to describe the relationship of dependents to you:

01=Spouse	24=Dependent of Your Minor Child
15=Legal Ward	53=Domestic Partner
17=Stepchild	38=Dependent of Domestic Partner
19=Child	
03=Minor Child Parent of Minor Dependent (This relationship is a Legal Ward, Stepchild, Child, or Dependent of Domestic Partner who is under age 18 and is the parent of any of your grandchildren listed as an eligible dependent on this application. Your grandchildren cannot be covered on your contract unless the parent of the grandchild is covered and is under 18.)	

Indicate "Yes" or "No" if any dependent older than age 26 is disabled.

Indicate "Yes" or "No" if your domestic partner or dependent of domestic partner is considered a "tax dependent" under federal law.

For yourself and all eligible dependents, provide the name of the physician or clinic. If selecting the Standard Plan, indicate "NONE."

SECTION 4 – ADDITIONAL INFORMATION

Indicate "Yes" or "No" and list the name of your grandchild's parent.

SECTION 5 – MEDICARE INFORMATION

Indicate "Yes" or "No" if you or any of your dependents (including your spouse/domestic partner) are covered by Medicare, and list the names of those covered. Provide the Health Insurance Claim number (HIC#) and the Medicare Part A and/or Part B effective date from the Medicare card for any individuals covered by Medicare.

SECTION 6 – OTHER COVERAGE

Provide information regarding any other group health insurance under which you or your dependents (including your spouse/ domestic partner) are covered. NOTE: "Other coverage" does not include supplemental insurance (examples, EPIC or DentalBlue).

SECTION 7 – SIGNATURE

Read the **TERMS AND CONDITIONS** on the last page.

1. When submitting an application for any reason, you are required to read the Terms and Conditions on the last page and sign the application. By signing the application, you are acknowledging that you have read and agree to the **TERMS AND CONDITIONS**.
2. Make a copy of the application for your records, and submit the application to your payroll representative or to ETF if you are an annuitant or continuant.
3. Your employer will complete Section 8 and provide a copy of the application to you. For annuitants/continuant, ETF will complete Section 8 and provide a copy of the application to you.



ETF Use Only

State of Wisconsin
Department of Employee Trust Funds (ETF)
HEALTH INSURANCE APPLICATION/CHANGE FORM

Employer Notes

1. APPLICANT INFORMATION			Member ID		SSN	
Applicant – First Name	Middle	Last	Previous Name		DOB	Gender
Home Mailing Address—Street and No.			City	State	Zip Code	Primary Telephone No. ()
Country (if not USA)						

MARITAL OR DOMESTIC PARTNERSHIP STATUS:
☐ Single ☐ Married/Domestic Partnership (date) _____ ☐ Divorced (date) _____ ☐ Widowed (date) _____
Spouse/Domestic Partner: SSN _____ Name _____ Previous Name _____
 Birth Date _____ Physician _____ Relationship: Spouse or Domestic Partner _____ Gender _____ Tax Dep. ☐ Yes ☐ No

<p>ELIGIBILITY STATUS (check one): <input type="checkbox"/> Employee <input type="checkbox"/> Graduate Assistant <input type="checkbox"/> Survivor <input type="checkbox"/> Continuant (COBRA) <input type="checkbox"/> Annuitant EMPLOYMENT STATUS (check one): <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Limited Term Employee <input type="checkbox"/> Retiree <input type="checkbox"/> N/A </p>	<p>I WANT MY COVERAGE TO BE EFFECTIVE: <input type="checkbox"/> As soon as possible (Employee will pay entire monthly premium until eligible for employer share.) <input type="checkbox"/> When employer contributes premium <input type="checkbox"/> It's Your Choice (January 1) </p> <table style="width: 100%;"> <tr> <td style="width: 50%; padding: 5px;">COVERAGE DESIRED: <input type="checkbox"/> Single <input type="checkbox"/> Family</td> <td style="width: 50%; padding: 5px;">HEALTH PLAN SELECTED:</td> </tr> </table>	COVERAGE DESIRED: <input type="checkbox"/> Single <input type="checkbox"/> Family	HEALTH PLAN SELECTED:
COVERAGE DESIRED: <input type="checkbox"/> Single <input type="checkbox"/> Family	HEALTH PLAN SELECTED:		

2. REASON FOR APPLICATION
 Reasons marked with an * require supporting documentation. Check the It's Your Choice Reference Guide for specific documentation requirements.

<p>A. Decline Coverage (Check one box below and go to Section 7 to sign and date your application.) <input type="checkbox"/> I do not wish to enroll at this time. <input type="checkbox"/> I do not wish to enroll at this time as I currently have other insurance coverage.</p> <p>B. Add Coverage (Check one box below and indicate the date of event. Update Section 3.): <input type="checkbox"/> New Hire <input type="checkbox"/> Birth <input type="checkbox"/> Adoption* <input type="checkbox"/> National Medical Support Notice* <input type="checkbox"/> Marriage or Domestic Partnership* <input type="checkbox"/> Spouse/Domestic Partner to Spouse/Domestic Partner Transfer (Your spouse/domestic partner must first complete a termination; coverage will be effective first of month following term date of spouse's/domestic partner's coverage.) <input type="checkbox"/> Loss of Other Coverage/Employer Contributions* <input type="checkbox"/> LTE New Hire (State Only) <input type="checkbox"/> Transfer from One Employer to Another Employer Name of Previous Employer: _____ <input type="checkbox"/> It's Your Choice Open Enrollment Period <input type="checkbox"/> Other: _____ Date of event: _____ </p> <p>C. Change Health Plan (Indicate current health plan, check one box below and indicate the date of the event. Update Section 3.): Current Health Plan: _____ <input type="checkbox"/> Move from Service Area <input type="checkbox"/> It's Your Choice Open Enrollment period <input type="checkbox"/> Due to Birth, Adoption*, Marriage/Domestic Partnership* Date of event: _____ </p>	<p>D. Change Coverage Level <input type="checkbox"/> Single to Family Coverage Due to (Check one box below and indicate the date of event. Update Section 3.): <input type="checkbox"/> Marriage/Domestic Partnership* <input type="checkbox"/> Birth <input type="checkbox"/> Adoption* <input type="checkbox"/> National Medical Support Notice* <input type="checkbox"/> Legal Ward* <input type="checkbox"/> Paternity Acknowledgement* <input type="checkbox"/> It's Your Choice Open Enrollment Period <input type="checkbox"/> Dependent Loss of Coverage <input type="checkbox"/> Other: _____ Date of event: _____ </p> <p><input type="checkbox"/> Family to Single Coverage — If your employee premium share is taken pre-tax, Internal Revenue Code Section 125 restricts mid-year changes to your coverage. My employee-required premium contribution is deducted (Check one box below and update Section 3.): <input type="checkbox"/> post-tax. Mid-year changes to your coverage level can be made at any time. <input type="checkbox"/> pre-tax, and my employee premium contribution has increased significantly. Date of event: _____ <input type="checkbox"/> pre-tax, and all my dependents became eligible for and enrolled in other group coverage. Date of event: _____ <input type="checkbox"/> pre-tax, and my last dependent has become ineligible for coverage under this group plan. Date of event: _____ <input type="checkbox"/> pre-tax, and I wish to change to single coverage during the annual It's Your Choice Open Enrollment period. </p>
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Applicant Name	Social Security Number
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2. REASON FOR APPLICATION (Continued)

E. Cancel Coverage

I wish to (Check one of the two following boxes.):

- ☐ cancel my current coverage.
☐ cancel my current family coverage to complete a spouse-to-spouse transfer.

My premiums are deducted: (Check one of the two following boxes):

- ☐ post-tax. Coverage may be cancelled at any time.
☐ pre-tax. Coverage may be cancelled only if a qualifying event occurs or during the annual It's Your Choice Enrollment period. (Check one of the following boxes if your premiums are deducted pre-tax and provide the date of event.)
☐ I am terminating employment.
☐ I am going on unpaid leave of absence.
☐ I am going to less than half-time employment.
☐ My employee premium contribution has increased significantly.
☐ I (and all my dependents, if applicable) became eligible for and enrolled in other group coverage.
☐ Annual It's Your Choice Open Enrollment period

Date of event: _____

F. Update Personal Data (Check all boxes below that apply.):

- ☐ Name Change:
Indicate former name _____
☐ Address Change (Indicate updated address in Section 1.)
☐ Telephone Number Change (Indicate updated telephone number in Section 1.)
☐ Date of Birth Correction to (Date) _____ for (Name) _____
☐ Social Security Number Correction to _____ for (Name) _____
☐ Marital Status and/or Marital Status Date Correction (Indicate updated marital status information in Section 1.)
☐ Medicare Information Update, complete Section 5.
☐ Other Insurance Update, complete Section 6.

G. Remove Dependents (Check one box below and indicate the date of event. Update Section 3 with dependents being removed.):

- ☐ Divorce*/Domestic Partnership Terminated*
☐ Death of dependent
☐ Removing adult dependent during annual It's Your Choice Open Enrollment period
☐ Disabled Dependent: Disability ends or dependent marries
☐ Disabled Dependent: Support and maintenance less than 50%
☐ Legal guardianship ends*
☐ Grandchild's parent turns 18
☐ Other: _____

Date of event: _____

Note: The deletion of a dependent due to loss of eligibility provides an opportunity for continuation coverage (COBRA) provided notice is given to the employer within 60 days of the event.

H. Add Dependents (Check one box below and indicate date of event. Update Section 3 with dependents being added.):

- ☐ Marriage/Domestic Partnership*
☐ Birth
☐ Adoption*
☐ National Medical Support Notice*
☐ Legal Guardianship*
☐ Paternity Acknowledgment*
☐ Adult Dependents, Annual It's Your Choice Period
☐ Dependent Loss of Other Group Coverage*
☐ Eligible Dependent Not Included on Initial Enrollment (Domestic partner or adult children cannot be Enrolled for this reason.)
☐ Disabled, Over Age 26*
☐ Other: _____

Date of event: _____

3. DEPENDENT INFORMATION — Complete all requested information.

Social Security Number	First Name	Middle	Last	Previous	Birth Date (mm/dd/ccyy)	Gender (M/F)	Rel. Code	Tax Dep? (Y/N)	Disabled? (Y/N)	Select Physician or Clinic



Applicant Name	Social Security Number
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4. ADDITIONAL INFORMATION

a. Are any of the dependents listed under Applicant/Dependent Information your grandchild? ☐ Yes ☐ No

If yes, name of parent _____

5. MEDICARE INFORMATION

Are you or any insured dependent covered under Medicare? ☐ Yes ☐ No If yes, list names of insured and Medicare dates.

Name: _____ Dates: Part A _____ Part B _____ HIC # _____

Name: _____ Dates: Part A _____ Part B _____ HIC # _____

6. OTHER COVERAGE

a. Other health insurance coverage? ☐ Yes ☐ No If yes, name of other insurance company _____

Name(s) of insured(s) _____

b. Is your spouse/domestic partner a State of Wisconsin employee or annuitant (including University of Wisconsin)? ☐ Yes ☐ No

7. SIGNATURE (Read the **TERMS AND CONDITIONS** on the last page and sign the application.)

By signing this application, I apply for the insurance under the indicated health insurance contract made available to me through the state of Wisconsin and I have read and agree to the **TERMS AND CONDITIONS**. A copy of this application is to be considered as valid as the original. In addition, to the best of my knowledge, all statements and answers in this application are complete and true. All information is furnished under penalty of Wis. Stat. § 943.395. Additional documentation may be required by ETF at any time to verify eligibility.

SIGN HERE
& Return to
Employer ➔

Date Signed (MM/DD/CCYY)

8. EMPLOYER COMPLETES (Coding Instructions are in the *Employer Health Insurance Administration Manual*.)

Employer Number 69-036-	Name of Employer	Program Option Code	Surcharge Code
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Group Number	Enrollment Type	Employee Type	Coverage Type Code	Health Plan Name or Suffix
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Previous Service – Complete Information

1. Employer, are you a WRS participating employer? ☐ Yes ☐ No If Yes, answer questions 2, 3 and 4.

2. Did employee participate under WRS prior to being hired by you? ☐ Yes ☐ No

3. Previous service check completed? ☐ Yes ☐ No

4. Source of previous service check: ☐ Online Network for Employers (ONE) ☐ ETF

Date Application Received by Employer (MM/DD/CCYY)	Date WRS Eligible Employment or Graduate Assistant Appointment Began or Hire Date (MM/DD/CCYY)
Event Date (MM/DD/CCYY)	Prospective Date of Coverage (MM/DD/CCYY)
Payroll Representative Signature	Telephone ()

COPY AND DISTRIBUTE ☐ **EMPLOYEE** ☐ **EMPLOYER**



HEALTH INSURANCE APPLICATION/CHANGE FORM TERMS AND CONDITIONS

1. To the best of my knowledge, all statements and answers in this application are complete and true. I understand that if I provide false or fraudulent information, misrepresentation or fail to provide complete or timely information on this application, I may face action, including, but not limited to, loss of coverage, employment action, and/or criminal charges/sanctions under Wis. Stat. § 943.395.
2. I authorize the Department of Employee Trust Funds (ETF) to obtain any information from any source necessary to administer this insurance.
3. I agree to pay in advance the current premium for this insurance, and I authorize my employer (the remitting agent) to deduct from my wages or salary an amount sufficient to provide for regular premium payments that are not otherwise contributed. The remitting agent shall send the premium on my behalf to ETF.
4. I understand that eligibility for benefits may be conditioned upon my willingness to provide written authorization permitting my health plan and/or ETF to obtain medical records from health care providers who have treated me or any dependents. If medical records are needed, my health plan and/or ETF will provide me with an authorization form. I agree to respond to questions from health plans and ETF, including, but not limited to, audits, in a timely manner.
5. I have reviewed and understand the eligibility criteria for dependents under this coverage and affirm that all listed dependents are eligible. I understand that children may be covered through the end of the month they turn 26. Children may also be covered beyond age 26 if they:
 - have a disability of long standing duration, are dependent on me or the other parent for at least 50% of support and maintenance, and are incapable of self-support; or
 - are full-time students and were called to federal active duty when they were under the age of 27 years and while they were attending, on a full-time basis, an institution of higher education.
6. I understand that if my insured domestic partner and/or dependent children of my insured domestic partner are not considered "tax dependents" under federal law, my income will include the fair market value of the health insurance benefits provided to my domestic partner and/or domestic partner's dependent children. Furthermore, I understand this may affect my taxable income and increase my tax liability.
7. I understand that it is my responsibility to notify the employer, or if I am an annuitant or continuant to notify ETF, if there is a change affecting my coverage, including but not limited to, a change in eligibility due to divorce, marriage or domestic partnership, a change in the "tax dependent" status of my domestic partner and/or domestic partner's dependent children, or an address change due to a residential move. Furthermore, failure to provide timely notice may result in loss of coverage, delay in payment of claims, loss of continuation rights and/or liability for claims paid in error. Upon request, I agree to provide any documentation that ETF deems necessary to substantiate my eligibility or that of my dependents.
8. I understand that if there is a qualifying event in which a qualified beneficiary (me or any dependents) ceases to be covered under this program, the beneficiary(ies) may elect to continue group coverage as permitted by state or federal law for a maximum of 18, 29, or 36 months, depending on the type of qualifying event, from the date of the qualifying event or the date of the notice to my employer, whichever is later. I also understand that if continuation coverage is elected by the affected qualified beneficiary and there is a second qualifying event (i.e., loss of eligibility for coverage due to death, divorce, marriage but not including non-payment of premium) or a change in disability status as determined by the Social Security Administration, continuation coverage, if elected subsequent to the second qualifying event, will not extend beyond the maximum of the initial months of continuation coverage. I understand that timely notification of these qualifying events must be made to ETF.
9. I understand that if I am declining enrollment for myself or my dependents (including spouse or domestic partner) because of other health insurance coverage, I may be able to enroll myself and my dependents in this plan if I or my dependents lose eligibility for that other coverage (or if the employer stops contributing toward that other coverage). However, I must request enrollment within 30 days after my or my dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if I have a new dependent as a result of marriage, domestic partnership, birth, acknowledgement of paternity, adoption, or placement for adoption, I may be able to enroll myself and my dependents if I request enrollment within 30 days after the marriage or effective date of the domestic partnership, or within 60 days after the birth, acknowledgement of paternity, adoption, or placement for adoption. To request special enrollment or obtain more information, I should contact my employer (or ETF if I am an annuitant or continuant).
10. I agree to abide by the terms of my benefit plan, as explained in any written materials I receive from ETF or my health plan, including, without limitation, the ***It's Your Choice*** guides.



DUPLICATE APPLICATION FOR YOUR RECORDS

ETF Use Only

State of Wisconsin Department of Employee Trust Funds (ETF) HEALTH INSURANCE APPLICATION/CHANGE FORM

Employer Notes

1. APPLICANT INFORMATION			Member ID		SSN	
Applicant – First Name	Middle	Last	Previous Name	DOB	Gender	Physician/Clinic
Home Mailing Address—Street and No. City State Zip Code			Primary Telephone No. ()		Country (if not USA)	

MARITAL OR DOMESTIC PARTNERSHIP STATUS:
☐ Single ☐ Married/Domestic Partnership (date) _____ ☐ Divorced (date) _____ ☐ Widowed (date) _____
Spouse/Domestic Partner: SSN _____ Name _____ Previous Name _____
 Birth Date _____ Physician _____ Relationship: Spouse or Domestic Partner _____ Gender _____ Tax Dep. ☐ Yes ☐ No

<p>ELIGIBILITY STATUS (check one): <input type="checkbox"/> Employee <input type="checkbox"/> Graduate Assistant <input type="checkbox"/> Survivor <input type="checkbox"/> Continuant (COBRA) <input type="checkbox"/> Annuitant</p> <p>EMPLOYMENT STATUS (check one): <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Limited Term Employee <input type="checkbox"/> Retiree <input type="checkbox"/> N/A</p>	<p>I WANT MY COVERAGE TO BE EFFECTIVE: <input type="checkbox"/> As soon as possible (Employee will pay entire monthly premium until eligible for employer share.) <input type="checkbox"/> When employer contributes premium <input type="checkbox"/> It's Your Choice (January 1)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">COVERAGE DESIRED: <input type="checkbox"/> Single <input type="checkbox"/> Family</td> <td style="width: 50%;">HEALTH PLAN SELECTED:</td> </tr> </table>	COVERAGE DESIRED: <input type="checkbox"/> Single <input type="checkbox"/> Family	HEALTH PLAN SELECTED:
COVERAGE DESIRED: <input type="checkbox"/> Single <input type="checkbox"/> Family	HEALTH PLAN SELECTED:		

2. REASON FOR APPLICATION
 Reasons marked with an * require supporting documentation. Check the It's Your Choice Reference Guide for specific documentation requirements.

<p>A. Decline Coverage (Check one box below and go to Section 7 to sign and date your application.) <input type="checkbox"/> I do not wish to enroll at this time. <input type="checkbox"/> I do not wish to enroll at this time as I currently have other insurance coverage.</p> <p>B. Add Coverage (Check one box below and indicate the date of event. Update Section 3.): <input type="checkbox"/> New Hire <input type="checkbox"/> Birth <input type="checkbox"/> Adoption* <input type="checkbox"/> National Medical Support Notice* <input type="checkbox"/> Marriage or Domestic Partnership* <input type="checkbox"/> Spouse/Domestic Partner to Spouse/Domestic Partner Transfer (Your spouse/domestic partner must first complete a termination; coverage will be effective first of month following term date of spouse's/domestic partner's coverage.) <input type="checkbox"/> Loss of Other Coverage/Employer Contributions* <input type="checkbox"/> LTE New Hire (State Only) <input type="checkbox"/> Transfer from One Employer to Another Employer Name of Previous Employer: _____ <input type="checkbox"/> It's Your Choice Open Enrollment Period <input type="checkbox"/> Other: _____ Date of event: _____</p> <p>C. Change Health Plan (Indicate current health plan, check one box below and indicate the date of the event. Update Section 3.): Current Health Plan: _____ <input type="checkbox"/> Move from Service Area <input type="checkbox"/> It's Your Choice Open Enrollment period <input type="checkbox"/> Due to Birth, Adoption*, Marriage/Domestic Partnership* Date of event: _____</p>	<p>D. Change Coverage Level <input type="checkbox"/> Single to Family Coverage Due to (Check one box below and indicate the date of event. Update Section 3.): <input type="checkbox"/> Marriage/Domestic Partnership* <input type="checkbox"/> Birth <input type="checkbox"/> Adoption* <input type="checkbox"/> National Medical Support Notice* <input type="checkbox"/> Legal Ward* <input type="checkbox"/> Paternity Acknowledgement* <input type="checkbox"/> It's Your Choice Open Enrollment Period <input type="checkbox"/> Dependent Loss of Coverage <input type="checkbox"/> Other: _____ Date of event: _____</p> <p><input type="checkbox"/> Family to Single Coverage — If your employee premium share is taken pre-tax, Internal Revenue Code Section 125 restricts mid-year changes to your coverage. My employee-required premium contribution is deducted (Check one box below and update Section 3.): <input type="checkbox"/> post-tax. Mid-year changes to your coverage level can be made at any time. <input type="checkbox"/> pre-tax, and my employee premium contribution has increased significantly. Date of event: _____ <input type="checkbox"/> pre-tax, and all my dependents became eligible for and enrolled in other group coverage. Date of event: _____ <input type="checkbox"/> pre-tax, and my last dependent has become ineligible for coverage under this group plan. Date of event: _____ <input type="checkbox"/> pre-tax, and I wish to change to single coverage during the annual It's Your Choice Open Enrollment period.</p>
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DUPLICATE APPLICATION FOR YOUR RECORDS

Applicant Name	Social Security Number
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2. REASON FOR APPLICATION (Continued)

E. Cancel Coverage

I wish to (Check one of the two following boxes.):

- ☐ cancel my current coverage.
☐ cancel my current family coverage to complete a spouse-to-spouse transfer.

My premiums are deducted: (Check one of the two following boxes):

- ☐ post-tax. Coverage may be cancelled at any time.
☐ pre-tax. Coverage may be cancelled only if a qualifying event occurs or during the annual It's Your Choice Enrollment period. (Check one of the following boxes if your premiums are deducted pre-tax and provide the date of event.)
☐ I am terminating employment.
☐ I am going on unpaid leave of absence.
☐ I am going to less than half-time employment.
☐ My employee premium contribution has increased significantly.
☐ I (and all my dependents, if applicable) became eligible for and enrolled in other group coverage.
☐ Annual It's Your Choice Open Enrollment period

Date of event: _____

F. Update Personal Data (Check all boxes below that apply.):

- ☐ Name Change:
 Indicate former name _____
☐ Address Change (Indicate updated address in Section 1.)
☐ Telephone Number Change (Indicate updated telephone number in Section 1.)
☐ Date of Birth Correction to (Date) _____ for (Name) _____
☐ Social Security Number Correction to _____ for (Name) _____
☐ Marital Status and/or Marital Status Date Correction (Indicate updated marital status information in Section 1.)
☐ Medicare Information Update, complete Section 5.
☐ Other Insurance Update, complete Section 6.

G. Remove Dependents (Check one box below and indicate the date of event. Update Section 3 with dependents being removed.):

- ☐ Divorce*/Domestic Partnership Terminated*
☐ Death of dependent
☐ Removing adult dependent during annual It's Your Choice Open Enrollment period
☐ Disabled Dependent: Disability ends or dependent marries
☐ Disabled Dependent: Support and maintenance less than 50%
☐ Legal guardianship ends*
☐ Grandchild's parent turns 18
☐ Other: _____

Date of event: _____

Note: The deletion of a dependent due to loss of eligibility provides an opportunity for continuation coverage (COBRA) provided notice is given to the employer within 60 days of the event.

H. Add Dependents (Check one box below and indicate date of event. Update Section 3 with dependents being added.):

- ☐ Marriage/Domestic Partnership*
☐ Birth
☐ Adoption*
☐ National Medical Support Notice*
☐ Legal Guardianship*
☐ Paternity Acknowledgment*
☐ Adult Dependents, Annual It's Your Choice Period
☐ Dependent Loss of Other Group Coverage*
☐ Eligible Dependent Not Included on Initial Enrollment (Domestic partner or adult children cannot be Enrolled for this reason.)
☐ Disabled, Over Age 26*
☐ Other: _____

Date of event: _____

3. DEPENDENT INFORMATION — Complete all requested information.

Social Security Number	First Name	Middle	Last	Previous	Birth Date (mm/dd/ccyy)	Gender (M/F)	Rel. Code	Tax Dep? (Y/N)	Disabled? (Y/N)	Select Physician or Clinic



DUPLICATE APPLICATION FOR YOUR RECORDS

Applicant Name		Social Security Number	
4. ADDITIONAL INFORMATION			
a. Are any of the dependents listed under Applicant/Dependent Information your grandchild? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of parent _____			
5. MEDICARE INFORMATION			
Are you or any insured dependent covered under Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list names of insured and Medicare dates. Name: _____ Dates: Part A _____ Part B _____ HIC # _____ Name: _____ Dates: Part A _____ Part B _____ HIC # _____			
6. OTHER COVERAGE			
a. Other health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of other insurance company _____ Name(s) of insured(s) _____			
b. Is your spouse/domestic partner a State of Wisconsin employee or annuitant (including University of Wisconsin)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
7. SIGNATURE (Read the TERMS AND CONDITIONS on the last page and sign the application.)			
By signing this application, I apply for the insurance under the indicated health insurance contract made available to me through the state of Wisconsin and I have read and agree to the TERMS AND CONDITIONS . A copy of this application is to be considered as valid as the original. In addition, to the best of my knowledge, all statements and answers in this application are complete and true. All information is furnished under penalty of Wis. Stat. § 943.395. Additional documentation may be required by ETF at any time to verify eligibility.			
SIGN HERE & Return to Employer ➔			Date Signed (MM/DD/CCYY)
8. EMPLOYER COMPLETES (Coding Instructions are in the <i>Employer Health Insurance Administration Manual</i> .)			
Employer Number 69-036-		Name of Employer	
Group Number		Enrollment Type	Employee Type
Coverage Type Code		Health Plan Name or Suffix	
Program Option Code		Surcharge Code	
Previous Service – Complete Information			
1. Employer, are you a WRS participating employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, answer questions 2, 3 and 4. 2. Did employee participate under WRS prior to being hired by you? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Previous service check completed? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Source of previous service check: <input type="checkbox"/> Online Network for Employers (ONE) <input type="checkbox"/> ETF			
Date Application Received by Employer (MM/DD/CCYY)		Date WRS Eligible Employment or Graduate Assistant Appointment Began or Hire Date (MM/DD/CCYY)	
Event Date (MM/DD/CCYY)		Prospective Date of Coverage (MM/DD/CCYY)	
Payroll Representative Signature		Telephone ()	

COPY AND DISTRIBUTE ☐ **EMPLOYEE**

☐ **EMPLOYER**



ET-2301 (REV 08/2012)

etf.wi.gov

Glossary

This glossary has many commonly used terms, but it is not a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See the Uniform Benefits policy in the It's Your Choice: Reference Guide or for the other plans, see the Medicare Plus (ET-4113) and Standard Plan (ET-2112) benefit booklets at etf.wi.gov/publications/insurance.htm.) To view the federal Uniform Glossary, see: etf.wi.gov/members/health-plan-summaries.htm. If you need a hard copy mailed to you, contact ETF at 1-877-533-5020.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Alternate Health Plans: The insurance plans in the State Group Health Program that offer Uniform Benefits. Examples of this are HMOs (Health Maintenance Organizations) and Preferred Provider Organizations (PPOs).

Annuitant: A retiree, beneficiary, or survivor of the retiree or beneficiary receiving benefits under the Wisconsin Retirement System (WRS).

Appeal: A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A preferred provider may not balance bill you for covered services.

CAHPS® (Consumer Assessment of Healthcare Providers & Systems): A survey used to measure satisfaction based on consumer experiences.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986): An option that allows an insured member to continue his/her employer-sponsored group health insurance coverage for a limited period of time under certain circumstances after losing eligibility for their health insurance. The member is responsible for paying the entire premium.

Coinsurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 10% for most services but 20% for durable medical equipment) of the allowed amount for the service. For example, if the health insurance or plan's allowed amount for an office visit is \$100, your coinsurance payment of 10% would be \$10. The health insurance or plan pays the rest of the allowed amount.

Complaint: When a member contacts ETF to appeal an insurance decision that is not favorable to the member.

Complications of Pregnancy: Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency Caesarean section are not complications of pregnancy.

Continuant: A subscriber enrolled under the federal COBRA or state continuation provisions following loss of eligibility for coverage in certain circumstances.

Copayment: A fixed amount (for example, \$5 for Level 1 prescription drugs) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Creditable Coverage: For purposes of Medicare Part D, the prescription drug coverage provided by the State Group Health Insurance Program is as good or better than the coverage a member can get by purchasing an individual commercial Part D plan. If a member needs Part D coverage in the future, there will be no penalty when creditable coverage has been maintained.

Dependent: A person who meets the specific eligibility criteria for coverage under the State of Wisconsin Group Health Insurance Program rules.

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Effective Date: The date on which the member becomes enrolled and entitled to benefits.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services you get in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

ETF: The Department of Employee Trust Funds, a state of Wisconsin agency that administers health insurance, retirement and other benefit programs for WRS participants and employers. Programs cover state and participating local employees and retirees.

Excluded Services: Health care services that your health insurance or plan doesn't pay for or cover.

Formulary: A list of covered prescription drugs. The State Group Health Insurance Program's formulary is available on Navitus Health Solutions' website at <https://www.navitus.com/Pages/default.aspx>.

Graduate Assistants: This group consists of graduate student assistants, employees-in-training, short-term academic staff and some visiting appointees. Members in this group are not enrolled in the Wisconsin Retirement System (WRS).

Glossary

Grievance: A written complaint filed with the health plan, PBM or ETF following a decision made by the health plan or PBM that was not favorable to the member.

Group Insurance Board: The governing body that sets policy and oversees the administration of the State of Wisconsin and Wisconsin Public Employers Group Health Insurance Programs.

Habilitation Services: Excluded health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Also referred to as custodial care.

Health Insurance: A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

HEDIS® (Healthcare Effectiveness Data & Information Set): Compares the performance of health plans with regard to the delivery of care and service.

HMO (Health Maintenance Organization): A health plan that uses a specific network of doctors, clinics, hospitals and other medical providers located in a specific geographic area. Members of HMOs are expected to receive services within that network.

Home Health Care: Health care services a person receives at home.

Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

In-network Coinsurance: The percent (for example, 10%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network coinsurance usually costs you less than out-of-network coinsurance under a PPO.

In-network Copayment: A fixed amount (for example, \$15) you pay for covered health care services such as specialty formulary prescription drugs to the provider who contracts with your pharmacy benefits manager. In-network copayments usually are less than out-of-network copayments.

It's Your Choice Open Enrollment Period: The annual opportunity for **eligible employees and annuitants** to change from one health plan to another, newly enroll or to change from single to family coverage for the upcoming year without restrictions.

Mandated Benefits: Benefits that are required by either federal or state law.

Medically Necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Medicare: The federal health insurance program for those who are eligible for coverage due to age, disability or blindness. The original federal Medicare program provides coverage under Medicare Part A and Part B.

Medicare Primary Payor: Where Medicare pays insurance claims first for retirees and/or their dependents who are aged 65 and older, and certain individuals with disabilities. Other group health insurance pays claims second, after Medicare's payment.

Medicare 1 (Family Premium Rate): The rate for a family plan where at least one member is enrolled in Medicare Parts A and B (and Medicare is the primary (first) payer) and at least one family member is not enrolled in Medicare.

Medicare 2 (Family Premium Rate): The rate for a family plan where all members are enrolled in Medicare Parts A and B and Medicare is the primary (first) payer.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. In a PPO, you'll pay more to see a non-preferred provider.

Non-Qualified Plan: Health plans that offer a limited amount of providers in a county.

Out-of-Network Coinsurance: In a PPO, the percent (for example, 30%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-Network Copayment: A fixed amount (for example, \$50) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-Pocket Limit (OOP): The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your copayments, out-of-network payments or other expenses toward this limit.

Participant: The subscriber or any of his/her dependents who have been specified for enrollment and are entitled to benefits.

PBM (Pharmacy Benefit Manager): The third-party administrator that the Group Insurance Board contracts with to administer prescription drug benefits.

Glossary

PCP (Primary Care Physician/Provider):

The PCP coordinates access to your health plan's coverage and services. Your PCP works with you and other medical providers to provide, prescribe, approve and coordinate medical care.

PDP (Prescription Drug Plan): A prescription drug plan that provides Medicare Part D coverage to Medicare-eligible participants covered under an annuitant contract.

Physician Services: Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan Benefits: Comprehensive health care services and prescription drug benefits that your health plan provides to its members in accordance with the contract language.

Plan Provider: A medical provider who has a contract with your health insurer or plan to provide services to you at a discount.

Plan Service Area: The geographic area in which a health plan provides coverage through its network.

PPO (Preferred Provider Organization):

A health plan that uses a network of doctors, clinics, hospitals and other medical providers in a specific geographic area, and also provides coverage outside of that network (at a higher out-of-pocket cost to the member). This arrangement can be attractive to participants who are generally satisfied with the health plan's providers, but who may occasionally need to use a particular specialist or need additional options while traveling. Currently, the only available Alternate Health Plans that offer a PPO are WPS Metro Choice and WEA Trust PPO. For other options, see the Standard Plan on Page 19.

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium: The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage: Pharmacy benefits manager coverage that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that by law require a prescription.

Preventive Services: Routine, preventive care is designed to help prevent disease or to diagnose it in the early stages. Find the list of federally required preventive services at <http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html>. Federal requirements may vary by age.

Primary Care Physician/Provider: See PCP.

Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Qualified Plan: In order for a health plan to be called qualified in a county, it must meet minimum provider availability requirements. The minimum requirements are: five primary care providers; a hospital if one exists in the county; a chiropractor; and a dental provider if the plan offers dental coverage. A health plan that is non-qualified is missing one or more of these types of providers, but is still an available option in the county.

Reconstructive Surgery: Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Referral: When your doctor recommends that you see another provider or specialist for care. The process for approving referrals varies by health plan, so it is important to find out your health plan's requirements.

Rehabilitation Services: Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Routine Preventive Services: See Preventive Services.

Schedule of Benefits: A document that details the specific benefits provided by your health plan including copays, deductibles and coinsurance, if any.

Self-Funded Plans: An arrangement under which the State of Wisconsin funds the payment of claims and fees for a hired third-party administrator (TPA). The TPA creates networks, and pays claims per the benefit contract. The Standard, SMP, Medicare Plus plans and Navitus Health Solutions are self-funded.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

Glossary

Subscriber: Any eligible employee, annuitant or continuant who enrolled for single or family coverage and whose dependents are also eligible for benefits.

TPA (Third-Party Administrator): A company that the Group Insurance Board contracts with to provide administrative services for self-funded plans. TPAs review for medical necessity, create networks, pay claims, etc.

Uniform Benefits: The standardized level of benefits offered to State of Wisconsin Group Health Insurance Program members through the HMOs and as the in-network benefit for PPOs, such as WEA Trust PPO and WPS Metro Choice.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Wisconsin Public Employer: Employers who have voluntarily chosen to participate in the Wisconsin Public Employers Group Health Insurance Program. This includes some villages, towns, cities, counties and school districts.

Wrap Benefit: A supplemental prescription drug benefit for Medicare-eligible participants covered under an annuitant contract who are enrolled in the State of Wisconsin or WPE Group Health Insurance Programs. This benefit will pay for prescription drug claims up to the level of the Uniform Benefits coverage after Medicare Part D has paid its portion.

WRS: Wisconsin Retirement System.

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Health Plan Contact Information

Anthem Blue

P.O. Box 105187
Atlanta, GA 30348
Tele: (800) 490-6201
24/7 Nurseline: (866) 647-6120
Website: anthem.com

Arise Health Plan

P.O. Box 11625
Green Bay, WI 54307-1625
Tele: (888) 711-1444
(920) 490-6900
Fax: (920) 490-6942
Website: WeCareForWisconsin.com

Dean Health Plan

1277 Deming Way
Madison, WI 53717
Tele: (800) 279-1301
(608) 828-1301
Fax: (608) 827-4212
Dean On Call: (800) 576-8773
Website: deancare.com/wi-employees

Group Health Cooperative of Eau Claire (GHC-EC)

P.O. Box 3217
Eau Claire, WI 54702
Tele: (888) 203-7770
(715) 552-4300
Fax: (715) 552-3500
FirstCare Nurseline: (800) 586-5473
Website: group-health.com

Group Health Cooperative of South Central Wisconsin (GHC-SCW)

1265 John Q. Hammons Drive
P.O. Box 44971
Madison, WI 53744-4971
Tele: (800) 605-4327
(608) 828-4853
Fax: (608) 662-4186
GHC Nurse Connect: (855) 661-7350
Website: ghcscw.com

Gundersen Lutheran Health Plan

1836 South Avenue
LaCrosse, WI 54601
Tele: (800) 897-1923
(608) 775-8007
Fax: (608) 775-8042
Nurse Advisor: (800) 362-9567
ext. 54454
Website: glhealthplan.org

HealthPartners Health Plan

P.O. Box 1309
Minneapolis, MN 55440-1309
Tele: (800) 883-2177
(952) 883-5000
Fax: (952) 883-5666
Careline: (800) 551-0859
Website: healthpartners.com/stateofwis

Health Tradition Health Plan

P.O. Box 188
LaCrosse, WI 54602-0188
Tele: (888) 459-3020
(608) 781-9692
Fax: (608) 781-4620
Nurseline: (855) 392-4050
Website: healthtradition.com

Humana

N19 W24133 Riverwood Drive #300
Waukesha, WI 53188
Tele: (800) 448-6262
HumanaFirst Nurse Advice:
(800) 622-9529
Website: humana.com, or direct at
apps.humana.com/egroups/wisconsin/
home.asp

Medical Associates Health Plans

1605 Associates Drive, Suite 101
P.O. Box 5002
Dubuque, IA 52004-5002
Tele: (800) 747-8900
(563) 556-8070
Fax: (563) 556-5134
Nurse Line: (800) 325-7442
Website: mahealthcare.com

MercyCare Health Plans

3430 Palmer Drive
P.O. Box 2770
Janesville, WI 53547-2770
Tele: (800) 752-3431
(608) 752-3431
Fax: (608) 752-3751
Nurse Line: (888) 756-6060
Website: mercycarehealthplans.com

Navitus Health Solutions

5 Innovation Court, Suite B
Appleton, WI 54914
Tele: (866) 333-2757
Fax: (920) 831-1930
Website: navitus.com

Navitus MedicareRx (PDP) (Prescription drug coverage for Medicare eligible retirees)

P.O. Box 999
Appleton, WI 54912-0999
Tele: (866) 270-3877
Fax: (920) 831-1930
Website: medicarerx.navitus.com

Network Health Plan

1570 Midway Place
P.O. Box 120
Menasha, WI 54952
Tele: (800) 826-0940
(920) 720-1300
Fax: (920) 720-1900
Nurse Direct: (800) 362-9900
Website: networkhealth.com

Physicians Plus Insurance Corp.

2650 Novation Parkway
Madison, WI 53713
Tele: (800) 545-5015
(608) 282-8900
Fax: (608) 327-0325
NursePlus: (866) 775-8776
Website: pplusic.com

Security Health Plan

1515 Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000
Tele: (800) 472-2363
(715) 221-9555
Fax: (715) 221-9500
24-hour Nurse Line: (800) 549-3174
Website: securityhealth.org/state

Standard Plans and SMP

WPS Health Insurance

1717 W. Broadway
P.O. Box 8190
Madison, WI 53707-8190
Tele: (800) 634-6448
Fax: (608) 243-6139
Website: wpsic.com/state

UnitedHealthcare of Wisconsin Inc.

P.O. Box 13187
3100 AMS Blvd.
Green Bay, WI 54307-3187
Tele: (800) 357-0974
Fax: (866) 674-5637
Care24: (888) 887-4114
Website: welcometouhc.com/state

Unity Health Insurance

840 Carolina Street
Sauk City, WI 53583-1374
Tele: (800) 362-3310
Fax: (608) 643-2564
Website: ChooseUnityHealth.com

WEA Trust

45 Nob Hill Road
P.O. Box 7338
Madison, WI 53707-7338
Tele: (800) 279-4000
(608) 276-4000
Fax: (608) 276-9119
Website: weatruststatehealthplan.com

WPS Metro Choice

1717 West Broadway
P.O. Box 8190
Madison, WI 53707-8190
Tele: (800) 634-6448
Fax: (608) 243-6139
Website: wpsic.com/state

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Madison, WI 53707-7931

1-877-533-5020 (toll free)
(608) 266-3285 (local to Madison)
Fax (608) 267-4549

